

**UFCW NORTHERN CALIFORNIA AND DRUG EMPLOYERS
HEALTH AND WELFARE TRUST FUND**
Mail: P. O. Box 8086 • Walnut Creek, CA 94596-8086
Telephone: (800) 552-2400 • Facsimile: (925) 746-7549
www.ufcwtrust.com

STUDENT CERTIFICATION

Semester

Months Enrolled

Quarter

Fall _____
Year

From: _____ To: _____
Mo/Day/Year Mo/Day/Year

Fall _____
Year

Spring _____
Year

(Example: Sept.6, 2007 to
Dec. 14, 2007)

Winter _____
Year

Summer _____
Year

Spring _____
Year

Summer _____
Year

I hereby certify that my dependent _____,

Social Security Number: _____ Date of Birth _____ Age _____

Meets the following criteria:

- 1) Unmarried
- 2) Age 19 through 23
- 3) Financially dependent upon me
- 4) A full-time student at the following recognized educational institution:

Name of School: _____

Street Address: _____

City - State - Zip: _____

- 5) My dependent is not gainfully employed for more than:

99 hours/month (for dependents of all employees)

A qualified student shall not have his/her Dependent eligibility affected by hours worked during any one semester or quarter break per school year.

ATTACH A COPY OF REGISTRATION CARD OR VERIFICATION FROM SCHOOL SHOWING FULL-TIME STATUS
NOTE: FULL-TIME STATUS IS DETERMINED BY THE INSTITUTION'S DEFINITION OF FULL-TIME STATUS

I further agree to notify UFCW-Employers Benefit Plans of Northern California, P. O. Box 8086, Walnut Creek, California 94596-8086, immediately in the event my dependent no longer meets the requirements as outlined above. I understand that a separate certification must be submitted for each school session period to maintain continuous coverage for my dependent.

Date Signed

Employee's Signature

Employee's Social Security Number

Student's Signature

Please see other side for important information →

EXTENSION OF COVERAGE IN CASES OF SERIOUS ILLNESS OR INJURY

Effective January 1, 2010, if your dependent child is covered as a full-time student and suffers from a serious illness or injury, he or she may be eligible under federal law for an extension of coverage for up to one year, if:

- 1) The Plan receives written certification from your covered child's treating physician that:
 - a) the child is suffering from a serious illness or injury, and
 - b) a leave of absence (or other change in enrollment) from his or her postsecondary institution is medically necessary and
- 2) the loss of postsecondary student status would otherwise result in a loss of health coverage under the Plan.

If these requirements are met, the Plan will extend the child's coverage for up to one year. This maximum one-year extension of coverage begins on the first day of the medically necessary leave of absence (or other change in enrollment) and ends one year later or on the date on which coverage would otherwise terminate under the terms of the Plan, whichever is earlier.

Please contact the Trust Fund Office immediately if you believe your child may qualify for an extension of coverage based on serious illness or injury.