

THE WASHINGTON WHOLESALERS HEALTH & WELFARE FUND

7130 COLUMBIA GATEWAY DRIVE, SUITE A

COLUMBIA, MD 21046

410-872-9500 phone 410-872-1275 fax

**STUDENT CERTIFICATION FOR DEPENDENT CHILD OVER AGE 19 THROUGH
THEIR 23RD BIRTHDAY**

Please Complete All Blanks

I certify that _____ whose date of birth is _____
(Print Name of Student)
_____, is my _____ and is a full-time student enrolled
(Date of Birth) (Daughter / Son)
at _____, an accredited school or
college
(Name of School or College)
on _____ and the expected date of graduation is _____
(Date) (Expected Date of Graduation)

My Son / Daughter is unmarried and financially dependent on me and I understand that his/her protection under my family coverage will terminate on the last day of the calendar month in which he/she marries or ceases to be financially dependent on me, or ceases to be a full-time student, or reaches his/her 23RD birthday.

I understand that it is my obligation to notify the Fund Office promptly upon occurrence of any of these events.

Member's Signature

Social Security Number

Date Signed

TO BE COMPLETED BY SCHOOL OR COLLEGE

School Insurance

Name of School Insurance Carrier through which
Student is covered during school term

(Name of Insurance Carrier)

(Address)

Policy Number

Certification

I certify the above named student is enrolled in this
school as a FULL TIME student.

AFFIX SCHOOL SEAL

(Name of School)

Enrolled for school term _____ / _____

Registrars Office Date

Print Name and Title

NOTE: (1) THE FUND WILL NOT PROVIDE FOR THE PAYMENT OF ANY PORTION OF MEDICAL EXPENSE WHICH IS COVERED UNDER THE POLICY OF INSURANCE PURCHASED OR PROVIDED THROUGH THE SCHOOL OR COLLEGE.

(2) A separate student certification must be filed for each dependent child over age 19.

(3) Student Certification must be renewed SEMESTER and without notice from Fund Office. No claim will be considered until renewal is filed.

(4) MAIL COMPLETED FORM TO THE WASHINGTON WHOLESALERS HEALTH & WELFARE FUND- AT THE ADDRESS ABOVE