

SHOPMEN'S LOCAL 527 BENEFIT FUND
2945 BANKSVILLE ROAD
PITTSBURGH, PA 15216
(412) 341-6183
Toll Free # 1 (800) 858-7870

STUDENT DEPENDENT COVERAGE
(APPLICABLE FOR UNMARRIED STUDENTS (FULL TIME) UNDER AGE 23)

I hereby certify that my dependent son / daughter

_____ print name of dependent _____ social security number _____ birthdate

is enrolled as a (full time) student at _____
name of accredited college or trade school

_____ address

for the 1st / 2nd or 3rd semester of the calender year _____ .

_____ Name of Member

_____ Address

_____ Social Security Number

Telephone # _____

Employer _____

Member covered by Blue Cross Yes () No ()

Member covered by HealthAmerica Yes () No ()

Member covered by Keystone Yes () No ()

Expected date of Graduation: _____

This coverage terminates when a dependent ceases to be a full time student or changes his/ her marital status, reaches age 23, or if the member's insurance terminates. Member must notify the Fund office of any change in status.

** THIS FORM MUST BE COMPLETED EVERY SIX MONTHS AND SUBMITTED WITH A LETTER FROM THE REGISTRATION OFFICE OR FINANCIAL AID OFFICE. THE LETTER MUST STATE THAT YOUR DEPENDENT IS ENROLLED, AND ATTENDING, AS A FULL TIME STUDENT.

IMPORTANT - If you have HealthAmerica or Keystone Insurance, you must contact them direct for student qualification. This form is for Blue Cross and Benefit Fund coverages only.

_____ Member Signature

_____ Date