

4TH DISTRICT IBEW HEALTH FUND

609 3rd Avenue
Chesapeake, OH 45619
304/525-0331



STUDENT DEPENDENT STATUS FORM

In order for the status of coverage for your dependent to be determined, please complete this form **in ink** and return it to the above address. If you need additional copies of this form, please contact the administration office.

MEMBER INFORMATION

Insured's Name: _____ Soc. Sec. Number: _____

Insured's Address: _____

STUDENT INFORMATION

Student's name: _____

Student's Social Security Number: _____ Date of Birth: _____

Relationship to Employee: _____ No. of Hours in School Daily: _____

Is the student gainfully employed while attending school? _____ If yes, please provide the name and address of the employer: _____

How many hours does the student work each week?: _____

Is the student provided group insurance while employed?: _____ (If yes please provide name and address of the Insurance Company: _____)

SCHOOL INFORMATION

Name and Address of School, College, or University: _____

Degree or Certificate Student is working toward: _____

Number of Credit Hours for each semester the student is enrolled in at the College or University: _____
(Please attach a letter from the School Registrar indicating whether the student is enrolled on a part-time or full-time basis.)

Is the student totally dependent upon you for support?: _____
(If yes, please attach a copy of the section of your income tax return which indicates the student is being claimed.)

I affirm, to the best of my knowledge, the above information is complete and accurate.

Insured's Signature: _____ Date: _____