# STUDENT VERIFICATION FORM

**For Full Time Students (Age 19-25)**

- □ **Health and Welfare benefits are granted for Full Time Students provided student is enrolled in an accredited education institution and is enrolled for at least 12-semester hours or the school's equivalent of 12-semester hours. Student eligibility will automatically terminate on the earliest of the following dates: May 31st if your student did not maintain full time status in consecutive school periods; or the Trust is notified that the student changed his/her full time status; the date on which the student gets married; or the day immediately before the student's 25th birthday.**
- □ **Updates will be granted through August 31st and again through the end of the year (i.e., seasonal holidays). Official notification from the school is required for each period.**
- □ **Summer coverage is provided if full-time status is maintained in consecutive school periods.**
- □ **Certain schools on Quarter System or certain Trade Schools may be updated for shorter periods.**
- □ **The Trust must be notified if student changes from Full Time Status.**
- □ **Overpayments will be applied to account if status changes and the Trust is not notified.**

***MEMBER MUST COMPLETE:***

1. **MEMBER'S ID NUMBER: _____**

   **MEMBER'S NAME: _____**

   **EMPLOYER NAME: _____**

   **STUDENT'S NAME: _____**

   **This will serve District No. 9, I. A. of M. & A. W. Welfare Trust as notice and verification that my dependent, _____ is fully dependent on me for support and is a full-time student at _____.**

2. **Please indicate if student attended school full time for previous term: □ Yes □ No**

3. _____ _____

   **DATE** **SIGNATURE OF MEMBER**

***SCHOOL REPRESENTATIVE MUST COMPLETE:***

1. **This will serve as verification that _____ is registered as a full-time student attending this institution (give full time dates which may include the current and/or next semester he/she has registered for):**

2. **FROM: _____ TO: _____**

   **SCHOOL: _____**

   **ADDRESS: _____**

   **CITY: _____ STATE: _____ ZIP: _____**

   **PHONE: _____ EXTENSION: _____**

3. _____ _____ **DATE: _____**

   **SIGNED** **TITLE**

***SCHOOL STAMP OR SEAL (REQUIRED):***

**District No. 9, I. A. of M. & A. W. Welfare Trust**
**12365 St. Charles Rock Road**
**Bridgeton, MO 63044 PHONE: 314-739-6442 - FAX: 314-739-2374** ***(NOTE: If a raised school seal is on this document, please mail the original to District 9.)***

**Revised 12/2007**