

SHEET METAL WORKERS LOCAL NO. 110 HEALTH FUND

609 3rd Avenue
Chesapeake, OH 45619

304/525-0331 Fax 304/525-5415

STUDENT DEPENDENT STATUS FORM

Please complete this form in ink and return to American Benefit Corporation, Attn: Katherine Kemper-Hammock at the address listed above. This form must be signed or stamped by your dependent's School Registrar's Office. Claims will not be processed without the completion of this form.

STUDENT SECTION: To be completed by Employee or Dependent

Name of Student _____ Date of Birth _____

Relationship to Employee _____ Soc. Sec. # _____

Name of College or University _____

Address of College or University _____

Degree or Certificate Student has elected _____

Student's Signature _____

EMPLOYEE SECTION: To be completed by Employee

Is student married? Yes _____ No _____ If yes, what is date of marriage? _____

Does student currently reside with you? _____ If not, where? _____

Does student work? Yes _____ No _____ If yes, where? _____

What was student's total W-2 reported earnings for last year? _____

Student's current hourly wage _____ Average hours worked _____

Except for SMW 110, give name/address of any other Insurance Company that provides Health/Dental/Vision/RX Coverage to the dependent.

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

Employee's Signature _____

Employee's Social Security # _____ Date _____

COLLEGE, SCHOOL, OR UNIVERSITY SECTION

School Registrar: Number of "Credit Hours" during semester _____

Is/was student enrolled on a full-time basis? Yes _____ No _____

Please advise for which semester you are verifying _____

Registrar's Signature _____

(Phone Number for Plan Administrator to verify _____)

REGISTRAR'S
SEAL/STAMP
HERE