UFT
WELFARE FUND

DEPENDENT STUDENT CERTIFICATION FORM*

THIS FORM IS USED FOR UNMARRIED FULL-TIME DEPENDENT STUDENTS.
A NEW CERTIFICATION MUST BE RECEIVED BY THE FUND:

- **WHEN THE STUDENT TURNS AGE 19.**
- **BY OCTOBER 1ST EVERY YEAR THEREAFTER, UNTIL THE AGE OF 23.**

*** In lieu of this form, a copy of your completed Dependent Student Certification Form that you submitted to your Health Carrier may be submitted.**

SECTION ONE: TO BE COMPLETED BY MEMBER

Member's Social Security Number: _____ If spouse/domestic partner is a UFT member, other S.S.#: _____

OR Member's UFT Welfare Fund Alternate ID #: _____ OR If spouse/domestic partner is a UFT member, UFT Welfare Fund Alternate ID #: _____

Member's Name: _____ (Last Name) _____ (First Name) _____ (MI)

Member's Address: _____ (Street)

_____ (City) _____ (State) _____ (Zip Code + 4)

DEFINITION OF DEPENDENT STUDENT: A full-time dependent student is a person who meets all of the following conditions: He/she is at least 19 years of age, unmarried, receives at least half of his/her support from the employee or member, and is enrolled full-time in an accredited school that issues a degree or diploma.

I certify that my dependent, _____ meets all of the following requirements for eligibility as a dependent student.

	Yes	No
A. 19 years of age or older	❒	❒
B. Unmarried	❒	❒
C. Receives at least half of his/her support from the employee or retired employee	❒	❒
D. Is a full-time student in an accredited school that issues a degree or diploma	❒	❒

I agree to advise the UFT Welfare Fund promptly of any changes in my child's dependent student status.

_____ (Member's Signature) _____ (Date)

SECTION TWO: TO BE COMPLETED BY STUDENT

Student's Name: _____ (Last Name) _____ (First Name) _____ (MI)

Student's DOB: _____ (Month) _____ (Day) _____ (Year) Student's Social Security Number: _____ Male ❒ Female ❒

Name of School: _____

Address of School: _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

SECTION THREE: 1. HAVE AN AUTHORIZED PERSON IN THE REGISTRAR'S OFFICE COMPLETE THE SECTION BELOW, **OR** 2. SUBMIT A LETTER FROM THE BURSAR'S OFFICE SHOWING FULL-TIME STATUS AND ATTACH TO THIS FORM, **OR** 3. DOWNLOAD AN OFFICIAL VERIFICATION OF ENROLLMENT FROM THE INSTITUTE'S WEBSITE AND ATTACH TO THIS FORM.

The student named in this form may be eligible for benefits under his/her parent's or legal guardian's insurance plan. In order for the UFT Welfare Fund to determine a students's eligibility, please complete the following information:

1. Is the student enrolled full-time? Yes ❒ No ❒ Fall _____ (year) Spring _____ (year)

2. Student's program of study? _____

3. Student's expected date of graduation? _____ (month) / _____ (year)

4. Is _____ (Name of Institution) Accredited? Yes ❒ No ❒

5. Registrar's Telephone Number: _____

_____
Authorized Signature/Title

Affix Institution Seal/Stamp Here

Mail Validated Form To: UFT Welfare Fund
52 Broadway
New York, NY 10004
Attention: Student Certification

NOTICE: Any person who knowingly and with the intent to defraud or deceive, files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act which may jeopardize benefits.