



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.

SECTION ONE: TO BE COMPLETED BY MEMBER

Member's Social Security Number:	<div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div>	If married to another UFT member, other S.S.#:	<div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div>
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[illegible]

Member's Address:

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

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.

- | | | |
|--|--------------------------|--------------------------|
| A. 19 years of age or older | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Unmarried | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Receives at least half of his/her support from the employee or retired employee | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Is a full-time student in an accredited school that issues a degree or diploma | <input type="checkbox"/> | <input type="checkbox"/> |

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

[illegible]

Student's DOB:

(Month) (Day) (Year)

Student's Social Security Number:

Male Female

[illegible]

Address of School:

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SECTION THREE: TO BE COMPLETED BY AUTHORIZED PERSON IN THE REGISTRAR'S OFFICE OF THE STUDENT'S EDUCATIONAL INSTITUTION (Affix the Institution's Seal or Stamp Where Indicated Below)

The student named in this form may be eligible for benefits under his or her parent's insurance plan. See Section One, above, for definition of dependent student. In order for the UFT Welfare Fund to determine a student's eligibility, please complete the following information:

1. Is the student enrolled full-time? Yes ☐ No ☐
- Fall _____ Spring _____
 year year
2. Student's program of study? _____
3. Student's expected date of graduation? ____ / ____
 month year
4. Is _____ Accredited? Yes ☐ No ☐
Name of Institution
5. Registrar's Telephone Number: _____

Authorized Signature/Title

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

Affix Institution Seal/Stamp Here

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.