

**UFCW-EMPLOYERS BENEFIT PLANS OF NORTHERN CALIFORNIA  
P. O. Box 9000, Walnut Creek, California 94598-0900**

**STUDENT CERTIFICATION**

**Semester**

**Months Enrolled**

**Quarter**

Fall \_\_\_\_\_  
Year

From: \_\_\_\_\_ To: \_\_\_\_\_  
Mo/Day/Year Mo/Day/Year

Fall \_\_\_\_\_  
Year

Spring \_\_\_\_\_  
Year

(Example: Sept. to Dec.)

Winter \_\_\_\_\_  
Year

Summer \_\_\_\_\_  
Year

Spring \_\_\_\_\_  
Year

Summer \_\_\_\_\_  
Year

I hereby certify that my dependent \_\_\_\_\_,

Social Security Number: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

**Meets the following criteria:**

- 1) Unmarried
- 2) Age 19 through 23
- 3) Financially dependent upon me
- 4) A full-time student at the following recognized educational institution:

Name of School: \_\_\_\_\_

Street Address: \_\_\_\_\_

City - State - Zip: \_\_\_\_\_

**5) My dependent is not gainfully employed for more than: (Complete for the following Funds)**

|   |  |
|---|--|
| UFCW Bay Area Health and Welfare Trust Fund                           | <input type="checkbox"/>   |
| UFCW Northern California Health & Welfare Trust Fund                  | <input type="checkbox"/> 63 hours/month (for dependents of Courtesy Clerks)<br>or<br><input type="checkbox"/> 91 hours/ month (for dependents of all other employees)  |
| UFCW Northern California & Drug Employers Health & Welfare Trust Fund | <input type="checkbox"/> 99 hours/month (for dependents of all employees)<br>A qualified student shall not have his/her Dependent eligibility affected by hours worked during any <u>one</u> semester or quarter <u>break per school year.</u> |

**ATTACH A COPY OF REGISTRATION CARD OR VERIFICATION FROM SCHOOL SHOWING FULL-TIME STATUS**  
**NOTE: FULL-TIME STATUS IS DETERMINED BY THE INSTITUTION'S DEFINITION OF FULL-TIME STATUS**

I further agree to notify UFCW-Employers Benefit Plans of Northern California, P. O. Box 9000, Walnut Creek, California 94598-0900, immediately in the event my dependent no longer meets the requirements as outlined above. I understand that a separate certification must be submitted for each school session period to maintain continuous coverage for my dependent.

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Employee's Social Security Number

\_\_\_\_\_  
Student's Signature

