

STUDENT CERTIFICATION

DEPENDENT STUDENT ELIGIBILITY REQUIREMENTS

This Plan will cover your unmarried children ages 19 through 23 provided they are primarily dependent on you for financial support and they are currently attending an accredited school or college as a full-time student. (Please refer to your Summary Plan Description [SPD] for additional requirements that may apply to stepchildren and foster children.)

Coverage for the Dependent student will end once he/she is no longer considered a full-time student at the accredited school or college, no longer primarily dependent on the Participant for financial support or, when he/she attains age 24, whichever occurs first.

If a Dependent child is an eligible Dependent and is not a full-time student during the summer break, coverage will be provided during the school break provided the student registers as a full-time student for the following semester.

EXTENSION OF COVERAGE IN CASES OF SERIOUS ILLNESS OR INJURY

Effective January 1, 2010, if your dependent child is covered as a full-time student and suffers from a serious illness or injury, he or she may be eligible under federal law for an extension of coverage for up to one year, if:

- 1) The Plan receives written certification from your covered child's treating physician that:
 - a) the child is suffering from a serious illness or injury, and
 - b) a leave of absence (or other change in enrollment) from his or her postsecondary institution is medically necessary' and
- 2) the loss of postsecondary student status would otherwise result in a loss of health coverage under the Plan.

If these requirements are met, the Plan will extend the child's coverage for up to one year. This maximum one-year extension of coverage begins on the first day of the medically necessary leave of absence (or other change in enrollment) and ends one year later or on the date on which coverage would otherwise terminate under the terms of the Plan, whichever is earlier.

Please contact the Trust Fund Office immediately if you believe your child may qualify for an extension of coverage based on serious illness or injury.

Student Certification Instructions

All Participants must complete this page and **sign both sides** of the certification below and on the other side. You must also complete the Working Student information on the other side whether your Dependent is working or not.

Attach a copy of the student’s registration card confirming the information below. If the registration card does not provide the information as requested below, please have an authorized representative at the school registrar’s office sign below for certification.

Student Name _____ Student ID number _____

School Name _____ School Phone Number (____) ____ - ____

School Address _____ City/State/Zip _____

My Dependent is taking # of units _____ credits _____ or hours _____, which is considered a full-time student at the above accredited school or college.

This certification covers the semester beginning ____ / ____ / ____ and ending ____ / ____ / ____
(give exact dates)

If your Dependent is not currently enrolled in summer school is he/she intending to enroll in the fall semester?

Yes____ No____

I certify that the above-named student is currently enrolled in this institution and as determined by this school, is considered a full-time student.

Registrar Signature _____ **Date Signed** ____ / ____ / ____

I hereby certify that the above information provided to you is accurate and that my child meets the above criteria for dependent student eligibility. I further agree to notify UFCW-Employers Benefit Plans of Northern California, P. O. Box 8086, Walnut Creek, California 94596-8086, 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.

Employee Signature (Required) _____

Date Signed ____ / ____ / ____

Employee Social Security Number: _____ - ____ - _____

This Form will be *Incomplete* unless you fill out the information and sign the other side →

Working Student Rule

The "Working Student" rule requires the dependent child to enroll in a health plan (including medical/drug, dental and/or vision coverage) offered by his/her employer when the cost to the employee for coverage is less than \$80 per month. Otherwise, benefits from this Plan will be reduced to 40% of what would otherwise be payable.

Is the student currently working? Yes* No

****If the student is employed, please complete the following information:***

Does your Working Student's Employer provide any health insurance coverage or funds which can be used for insurance coverage? Yes No

Name of Dependent Student's Employer

Employer: _____

Street Address: _____

City - State - Zip: _____

Telephone Number: _____

If your Dependent Student is enrolled in a Plan, mark the 'Yes' box below and provide information about the Insurance Carrier.

If your Dependent Student is not enrolled in a Plan, mark the 'No' box and check the appropriate box which follows.

Dependent Student Enrolled in Medical/Rx Plan?

Yes Effective date: Carrier: Check here if HMO

No Check one of the following:
 Not offered by Employer Offered by Employer Employee monthly cost: \$

Dependent Student Enrolled in Dental Plan?

Yes Effective date: Carrier:

No Check one of the following:
 Not offered by Employer Offered by Employer Employee monthly cost: \$

Dependent Student Enrolled in Vision Plan?

Yes Effective date: Carrier:

No Check one of the following:
 Not offered by Employer Offered by Employer Employee monthly cost: \$

Next Open Enrollment Period for Dependent Student's Employer Month: Year:

FRAUD NOTICE: I UNDERSTAND THAT I MAY BE SUBJECT TO CIVIL AND/OR CRIMINAL PENALTIES FOR COMMITTING A FRAUDULENT INSURANCE ACT IF I KNOWINGLY PROVIDE ANY MATERIALLY FALSE INFORMATION TO, OR CONCEAL ANY MATERIAL FACTS FROM, THE TRUST FUND WITH THE INTENT TO DEFRAUD OR MISLEAD THE TRUST FUND.

I CERTIFY THAT THE INSURANCE INFORMATION IS ACCURATE. I UNDERSTAND THAT THIS INFORMATION WILL BE AUDITED PERIODICALLY AND THAT ANY INACCURATE INFORMATION MAY RESULT IN LIABILITY FOR A REFUND FOR OVERPAYMENT.

Employee Signature (Required) _____ **Date Signed** __/__/____

Employee's Social Security #: _____