



# IBEW LOCAL 234 HEALTH AND WELFARE PLAN



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## STUDENT CERTIFICATE FOR DEPENDENT CHILD OVER AGE 19

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY AND RETURN TO  
**IBEW LOCAL 234 HEALTH AND WELFARE PLAN**  
**PO BOX 670**  
**SAN JOSE, CA 95109**

I certify that \_\_\_\_\_ is my son / daughter  
(Print your child's name) (circle one)  
and is a full time student enrolled at \_\_\_\_\_  
(Print name of school)  
as of \_\_\_\_\_ and expected to graduate \_\_\_\_\_  
(Print date)

He/She is not married and is financially dependent on me and I understand that his/her coverage will terminate on the last day of the month in which he/she marries, ceases to be financially dependent on me, reaches the age 25, or is no longer a full time student. I also understand that it is my obligation to notify the Fund Office immediately upon the occurrence of any of these events.

\_\_\_\_\_  
(Member's Signature) (Social Security Number) (Date)

### TO BE COMPLETED BY SCHOOL OR COLLEGE

I certify that the above named student is enrolled in this school as a full time student:

Name of school \_\_\_\_\_

Enrolled for school term \_\_\_\_\_ / \_\_\_\_\_ Number of credit hours \_\_\_\_\_

Registrar's Signature \_\_\_\_\_ Date \_\_\_\_\_

Print name and Title \_\_\_\_\_

Phone number where this information can be verified \_\_\_\_\_

- ❖ A separate student certificate must be filed for each dependent child over age 18.
- ❖ Student Certification must be updated each semester with or without notice from the Fund Office.
- ❖ No claims will be considered after September 30 for the Fall semester and January 31 for the Winter/Spring semester, until the completed Student Certificate is received by the Fund Office.  
(See Plan SPD for Details)