EMPLOYMENT PARTNERS BENEFITS FUND
50 Abele Rd., Ste. 1005
Bridgeville, PA 15017
PHONE: (412) 363-2700 FAX: (412) 363-0580

Member Name: _____ Member SS#_____
Address: _____
_____

SCHOOL VERIFICATION STATEMENT

FOR DEPENDENTS 19 to 25 YEARS OF AGE

In order to continue dependent coverage, it is necessary that we receive this statement, signed by you, the member, and an authorized school official verifying that _____ is a full time student. If your dependent is not a full time student, please review with your dependent the enclosed cobra notice.

Member's Signature: _____
Soc. Sec. No. : _____
Member's Employer: _____

Name of Student: _____ Date of birth: _____
Student's Soc. Sec. No. : _____

Name of school : _____

Address of school : _____

Number of years student has attended : _____ Grad. Date : _____

Status this term : _____
(FRESHMAN, SOPHMORE, JUNIOR, SENIOR)

Verify for months of : _____ Thru _____
(IF ENROLLED DATES DIFFER, PLEASE ADVISE.)

Authorized School Official Signature : _____
(TITLE) : _____

Please complete and return this form to the Fund Office.
Thank you.