

# Dependent Student Semester Verification Form

\_\_\_\_\_  
Member\_\_\_\_\_  
Date\_\_\_\_\_  
Dependent Student

Dear, \_\_\_\_\_

Please update our files by submitting the following information. This will enable us to expedite the processing of your claims when submitted. No dental claims will be processed and no vision verification numbers will be given to providers until this form is completed in its entirety and returned to the Benefit Trust office.

For the 2023-2024 school year:

1. Is this dependent a full time student?:    Yes        No   

2. Is he/she primarily (more than 51%) dependent on you for support and maintenance?    Yes        No   

3. If your answer is "yes" to Numbers 1 and 2 above, please have the registrar of the school where the dependent attends complete the following information and affix the school seal.

\_\_\_\_\_  
Fall 2023 semester credit hours:\_\_\_\_\_  
Spring 2024 semester credit hours:\_\_\_\_\_  
The anticipated date of graduation:\_\_\_\_\_  
Name and address of college or school:

Thank you for providing the information requested. Please sign below and return as quickly as possible to insure continuation of benefits. I certify that all of my responses on this form are accurate and correct. I understand that it is my responsibility to notify the fund office of any changes in the above information.

\_\_\_\_\_  
Member Signature:\_\_\_\_\_  
Date