

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 2026-2027 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 the dependent attends complete the following information and affix the school seal or provide supporting documents showing student is full time with 12 or more credits.

Fall Semester 2026 semester credit hours

Spring 2027 semester credit hours

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 ensure 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