MI UFCW
UNIONS AND EMPLOYERS
HEALTH AND WELFARE PLAN
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STUDENT DEPENDENT COVERAGE

Unmarried children who are over 19 years of age may remain eligible for coverage until the date of their 23rd birthday, provided they are enrolled as a full-time student (at least 12 credit hours) in an accredited school, college or university and remain primarily financially dependent on the eligible employee.

Effective April 1, 2010, a dependent child covered by the Plan who loses full-time student status due to a serious illness or injury will be able to continue coverage under the Plan as a dependent for up to one year upon a leave of absence or other change in enrollment. The child's doctor must also certify in writing that the child is suffering from a serious illness or injury that requires this medical leave. This one-year maximum period can end sooner if the coverage for the child under the Plan as a dependent terminates for other reasons. For example, other reasons are the child's reaching age 23 or the termination of the full-time employee's coverage for himself and his dependents for any other reason.

In order to ensure that your unmarried student-dependent will be eligible for coverage under the Plan, you must complete Part I of this form and have Part II completed by the school at which your child is enrolled to certify that he/she is a full-time student. The completed form must be returned to the Fund Office.

STUDENT DEPENDENT COVERAGE

Please see page 1 for important information regarding student dependent coverage.

PART I ***To be completed by the eligible participant***

Participant Name:	SSN#:	
Student's address (if different from employee)	Phone #:	
City:	State:	Zip:
Student Dependent's Name:		
Relation to participant: ☐ Son ☐ Daughter ☐ Stepson ☐ Stepdaughter ☐ Grandchild		
Name of School:		
Address:		
City:	State:	Zip:

I certify that my dependent is a full-time student at the school listed above and that the forgoing information, to the best of my knowledge, is true, correct and complete. I understand any willfully false statement on this form is a federal crime that is punishable by fine or imprisonment.

****I understand that it is my obligation to notify the Plan Office if there is any change to my student dependent's full-time student status and that I will be responsible for any and all employee co-premiums claims paid on my dependent's behalf if I fail to do so.****

Participant's Signature: _____ Date:_____

PART II ***To be completed by school, college or university***

Name of School:
Student's Name:
What semester is the student enrolled for:
Number of credit hours student is enrolled for during this period:
Date drop period ends (for any type of refund)

I certify that the forgoing information, to the best of my knowledge, is true, correct and complete. I understand any willfully false statement on this form is a federal crime that is punishable by fine or imprisonment.

Registrar's Signature: _____ Date: _____

Title: _____ Phone #: _____