



Laborers Health and Welfare Trust Fund for Northern California
220 Campus Lane, Fairfield, CA 94534-1498 • Telephone: (707) 864-2800 • Toll Free: 1-(800) 244-4530

**APPLICATION FOR STUDENT
EXTENDED DEPENDENT COVERAGE**

(Doc. ØF)

Laborer must complete - Application will not be processed unless all questions are answered.

LABORER'S NAME

SOCIAL SECURITY NO.

STREET ADDRESS

CITY

STATE

ZIP CODE

Please Answer the Following Regarding the Student

FULL NAME
OF STUDENT

DATE
OF BIRTH

NAME OF EDUCATIONAL INSTITUTION

TELEPHONE NO.

STREET ADDRESS

CITY

STATE

ZIP CODE

Enrolled for the (check one) or, if available, please attach a copy of school's transcript:

FALL Semester SPRING Semester

Indicate Period: FROM

THRU

Laborer's Statement

Your dependent must meet the Plan's definition for "student dependent" and all of the requirements listed below. Please answer the following questions:

- ▶ Is your dependent married? Yes No
- ▶ Is your dependent enrolled in an accredited institution for at least 8 units? Yes No
- ▶ Did you or will you claim your dependent on your Federal Tax return? Yes No

I certify that the dependent shown above meets all of the requirements by the Plan for student dependent coverage. I understand that I must notify the Fund Office immediately in writing if my child marries, ceases to be a full time student, or ceases to be a dependent under the Internal Revenue Service code. I understand that the Fund Office has the right to verify my dependent's status with the above institution and that I agree to submit an Application for Student Dependent Coverage form at least once a year for the dependent shown above.

I certify under penalty of perjury under the laws of the state of California that the foregoing statements are true, correct, and complete to the best of my knowledge.

Laborer's Signature:

Date: