



Leadership for Public Education
HEALTH AND WELFARE FUND

FULL TIME STUDENT CERTIFICATION

THIS SECTION TO BE COMPLETED BY THE EMPLOYEE

Name of Employee _____ Soc. Sec. # _____

Address _____

City _____ State _____ Zip _____

Employer _____

Dependent Student's Full Name _____

Dependent Student's Social Security Number _____

Dependent Student's Date of Birth _____

Dependent Student's Marital Status _____

Dependent Student's Relationship to Employee _____

Does the Dependent Student receive more than 50% of support from employee? _____

Dependent Student's School (name and address) _____

WE HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF OUR KNOWLEDGE AND AUTHORIZE RELEASE OF THIS INFORMATION WITH RESPECT TO THIS CERTIFICATION.

Employee Signature

Student Signature

DO NOT DETACH

THIS SECTION TO BE COMPLETED BY THE REGISTRAR OF THE SCHOOL OR ATTACH AN OFFICIAL ENROLLMENT VERIFICATION FORM FROM THE SCHOOL.

_____ is a full time student at the _____
Student's Name *Full Name of School*

Further, the above named student is registered for classes for the period _____ to _____.

The student is expected to graduate _____.

Dates of Present Term: From _____ to _____.

SCHOOL SEAL

Signature — Registrar

NOTE: Any fee for the completion of this form is the responsibility of the employee.

RETURN TO:

PSEA Health and Welfare Fund
400 North Third Street, PO Box 1724
Harrisburg, PA 17105-1724

