Mail: P. O. Box 4100 · Concord, CA 94524-4100
Telephone: (800) 552-2400 · Facsimile: (925) 746-7549
www.ufcwtrust.com

UEBT & UCBT Retiree Health Plan
STUDENT CERTIFICATION

DEPENDENT STUDENT ELIGIBILITY UNDER THE UEBT RETIREE HEALTH PLAN REQUIREMENTS

This Plan will cover your unmarried child(ren) ages 19 through 23 provided they are primarily Dependent on you for financial support and they are currently attending an accredited school or college as a full-time student. (Please refer to your Summary Plan Description [SPD] for additional requirements that may apply to stepchildren and foster children).

Coverage for your full-time Dependent student will end at the earliest of:

- The last day of the month in which your child is no longer considered to be a full-time student at the accredited school or college
- The last day of the month in which your child marries
- The last day of the month in which your child attain the age limit of 24
- The last day of the month in which your child is no longer financially dependent on you, the Member

If an eligible Dependent child is not a full-time student during the summer break, coverage can be provided during the school break if the full-time student was enrolled within the previous semester and registered as a full-time student for the upcoming semester.

DEADLINE FOR SUBMITTING STUDENT CERTIFICATION

Dependent full-time students are required to submit the attached documentation in order to grant coverage within **sixty (60) days** from the start date of their semester/quarter.

Example: The student's semester/quarter begins on August 22nd. The Student Certification form along with any other documentation will need to be submitted no later than October 21st.

In the event that the Student Certification form is not returned within the allotted timeframe, the Dependent student will not be granted any eligibility during this period. Another Student Certification form can be submitted for the following semester/quarter if the student meets all of the requirements.

EXTENSION OF COVERAGE IN CASES OF SERIOUS ILLNESS OR INJURY

If your Dependent child is covered as a full-time student and suffers from a serious illness or injury, he or she may be eligible under federal law for an extension of coverage for up to one year, if:

1) The Plan receives written certification from your covered child's treating physician that: a) the child is suffering from a serious illness or injury, and b) a leave of absence (or other change in enrollment) from his or her postsecondary institution is medically necessary' and

2) The loss of postsecondary student status would otherwise result in a loss of health coverage under the Plan.

If these requirements are met, the Plan will extend the child's coverage for up to one year. This maximum one-year extension of coverage begins on the first day of the medically necessary leave of absence (or other change in enrollment) and ends one year later or on the date on which coverage would otherwise terminate under the terms of the Plan, whichever is earlier.

Please contact the Trust Fund Office at (800) 522-2400 immediately if you believe your child may qualify for an extension of coverage based on serious illness or injury.

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STUDENT CERTIFICATION INSTRUCTIONS

All Participants **must** complete and sign both of the attached forms.

You must also complete the Working Dependent information on the other side whether your Dependent is working or not.

Attach a copy of the student's registration card confirming the information below. If the registration card does not provide the information as requested below, please have an authorized representative at the school registrar's office sign below for certification.

Student Name _____ Student ID number _____

School Name _____ School Phone Number (_____) _____-_____

School Address _____ City/State/Zip _____

My Dependent is taking # of units_____ credits _____ or hours_____, which is considered a full-time student at the above accredited school or college.

This certification covers the semester beginning:

__ __ / __ __ / __ __ __ __ and ending __ __ / __ __ / __ __ __ __
(give exact dates)

If your Dependent is not currently enrolled in summer school is he/she intending to enroll in the fall semester?

Yes____ No___

I certify that the above-named student is currently enrolled in this institution and as determined by this school, is considered a full-time student.

Registrar Signature: _____Date Signed _____/_____/_____

I hereby certify that the above information provided to you is accurate and that my child meets the above criteria for Dependent student eligibility. I further agree to notify UEBT Retiree Health Plan , P. O. Box 4100, Concord, California 94524-4100, immediately in the event my Dependent no longer meets the requirements as outlined above. I understand that a separate certification must be submitted for each school session period to maintain continuous coverage for my Dependent. I also understand if my child is not attending school during the summer my child must have been enrolled in school during the previous semester and must enroll in the upcoming semester for coverage during the summer break.

Retiree Signature: _____**Date Signed: _____/_____/_____**

Retiree Social Security Number/Member ID: _____

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WORKING DEPENDENT RULE

All Participants **must** complete both sides of this form, sign where required and return to the Trust Fund office.

The "Working Dependent" rule requires the Dependent child to enroll in a health plan (including medical/drug, dental and/or vision coverage) when it is offered by their employer. In addition, the student must elect the coverage option that is at least as comprehensive as the coverage provided to the student through the UEBT Retiree Health Plan.

Is the student currently working? [ ] Yes* [ ] No

*If the student is employed, please complete the following information:

Does your Working Dependent's Employer provide any health insurance coverage or funds which can be used for insurance coverage?

[ ] Yes [ ] No (I acknowledge that if my working Dependent's employer does NOT offer medical coverage, a letter from my Working Dependent's Employer, on company letterhead, will be required verifying that coverage is not available.) Initials: _____

Name of Dependent's Employer:

Employer Name: _____ Phone Number (_____) _____-_____

School Address _____ City/State/Zip _____

If your Working Dependent is enrolled in a Plan, mark the 'Yes' box below and provide information about the Insurance Carrier.
If your Working Dependent is not enrolled in a Plan, mark the 'No' box and check the appropriate box which follows.

Dependent Enrolled in Medical/Rx Plan?

[ ] Yes Effective date: Carrier: Check here if HMO [ ]
[ ] No Check one of the following:
[ ] Not offered by Employer [ ] Offered by Employer

Dependent Enrolled in Dental Plan?

[ ] Yes Effective date: Carrier:
[ ] No Check one of the following:
[ ] Not offered by Employer [ ] Offered by Employer

Turn over →

Dependent Enrolled in Vision Plan?

[ ] Yes Effective date: Carrier:
[ ] No Check one of the following:
[ ] Not offered by Employer [ ] Offered by Employer

Next Open Enrollment Period for Working Dependent's Employer:

Month: _____ Year: _____

(Documentation will be required from your Dependent' child's employer on company letterhead identifying the date of the next open enrollment and that changes are not allowed outside of open enrollment.)

FRAUD NOTICE: I UNDERSTAND THAT I MAY BE SUBJECT TO CIVIL AND/OR CRIMINAL PENALTIES FOR COMMITTING A FRAUDULENT INSURANCE ACT IF I KNOWINGLY PROVIDE ANY MATERIALLY FALSE INFORMATION TO, OR CONCEAL ANY MATERIAL FACTS FROM, THE TRUST FUND WITH THE INTENT TO DEFRAUD OR MISLEAD THE TRUST FUND. I CERTIFY THAT THE INSURANCE INFORMATION IS ACCURATE. I UNDERSTAND THAT THIS INFORMATION WILL BE AUDITED PERIODICALLY AND THAT ANY INACCURATE INFORMATION MAY RESULT IN LIABILITY FOR A REFUND FOR OVERPAYMENT.

Retiree Signature (Required): _____ **Date Signed: ____/_____/____**

Retiree's Social Security number/Member ID: _____