

BRONXVILLE PUBLIC SCHOOL EMPLOYEES' BENEFIT TRUST

DEPENDENT STUDENT CERTIFICATION

PLEASE PROVIDE THE FOLLOWING INFORMATION FOR EACH DEPENDENT CHILD (AGES 19-24).
THIS INFORMATION IS REQUIRED EACH SEMESTER

MEMBER INFORMATION/TO BE COMPLETED BY MEMBER

MEMBER NAME: _____

MEMBER SS #: _____

DEPENDENT'S NAME: _____

THE FOLLOWING INFORMATION IS TO BE COMPLETED BY THE REGISTRAR'S OFFICE OF THE SCHOOL YOUR DEPENDENT IS ATTENDING. FAILURE TO HAVE THIS FORM COMPLETED WILL RESULT IN A DELAY OF COVERAGE FOR YOUR DEPENDENT.

SCHOOL INFORMATION /TO BE COMPLETED BY SCHOOL REGISTRAR

NAME, ADDRESS, AND PHONE NUMBER OF SCHOOL DEPENDENT IS ENROLLED IN:

IS DEPENDENT ENROLLED AND ATTENDING CLASSES AS A FULL-TIME STUDENT?

YES NO IF NO EXPLAIN:

DATES OF: A. CURRENT SCHOOL ENROLLMENT: FROM _____ TO _____

B. GRADUATION (EXPECTED): _____

REGISTRAR'S STAMP

SCHOOL CONTACT PERSON

DATE

PLEASE RETURN THIS FORM TO:

PREFERRED GROUP PLANS, INC.

P.O. BOX 15136

ALBANY, NY 12212-5136

TEL. 1-800-573-7474 FAX 518-641-0325