SOUTHERN CALIFORNIA DRUG BENEFIT FUND
Return to: P.O. Box 27920 Los Angeles CA 90027-0920
Ph: (323) 666-8910x501 Fax: (323) 913-0484

STUDENT CERTIFICATION

STUDENT ELIGIBILITY

Unmarried children between the ages of 19 and 24 of eligible Participants may qualify for medical and dental plan coverage if they are registered as students at a recognized educational institution or technical or trade school on a full-time basis and are dependent on their parents for support.
The child must remain enrolled as a full-time student for the entire term in order for coverage to remain in force.
A student dependent will be covered by the plan in which his or her parent is enrolled. If a dependent is not registered as a full-time student at the time s/he attains age 19, his/her coverage will cease. If s/he subsequently registers at a recognized institution, in order to obtain coverage s/he must submit this Student Certification form documenting his/her attendance or registration in high school or other educational institution.

INSTRUCTIONS FOR COMPLETION

The parent participant must complete Part A of this form. The Registrar of the educational institution or technical or trade school must complete Part B of this form and stamp it with the official seal of the institution. To apply for continued eligibility during a school recess, the participant must complete Part C of this form. To apply for Disabled Student Coverage, the child's treating physician must complete Part D of this form. The form must be returned either to the Participant's union local or to the Administrative Office of the Fund.

ELIGIBILITY DURING A SCHOOL RECESS

If a child was covered as a student dependent during the term immediately preceding a school recess, coverage will be continued during the recess if: (1) the child enrolls as a full-time student for the term immediately following the recess (and submits a new Student Certification form for that term, with Parts A and B completed); and (2) Part C of this form is completed and returned to the Fund Office.
If the child does not return to school as required in (1), above, his/her coverage will be retroactively terminated on the first day of the month following the month in which the preceding school term ended. You will be required to reimburse the Fund for any benefits provided to your child following his/her retroactive termination date.

DISABLED STUDENT COVERAGE

Student dependents who become unable to maintain full-time enrollment due to serious illness or injury may qualify for continued Fund coverage. For details, please read the enclosed notice entitled, "Information About Disabled Student Coverage."

PART A *To be completed by Participant*

Participant's Last Name _____ Participant's First Name _____ Participant's SSN __ __ __ - __ __ - __ __ __ __ Participant's DF # __ __ __ __ __ __ __

Street Address _____ City/State/Zip _____

Telephone Number (__ __ __) __ __ __ -- __ __ __ __ Union Local __ __ __ __ Employer _____

Student's Last Name_____ Student's First Name_____ Student's Date of Birth __ __ / __ __ / __ __ __ __

Student's Soc. Sec. # __ __ __ - __ __ - __ __ __ __

Does your spouse have a job which makes him/her eligible for coverage under this Trust Fund? ☐Yes ☐No If yes, name of spouse _____

If no, does any other family member have a job which makes him/her eligible for coverage under the UFCW Drug Trust Fund? ☐Yes ☐No

If yes, please provide the following information about the other family member eligible for Drug Trust Fund coverage:

Name _____ SSN __ __ __ -- __ __ -- __ __ __ __ Relationship to Participant _____

I hereby certify that my child meets the requirements for student coverage as set forth above.

☒_____ __ __ / __ __ / __ __ __ __

Signature of Participant Date

PART B *To be completed by Registrar of educational institution*

School Name _____ Phone __ __ __ -- __ __ __ -- __ __ __ __

Street Address _____ City/State/Zip _____

Phone (__ __ __) __ __ __ -- __ __ __ __

Student Number _____ Units Carried _____

For semester beginning __ __ / __ __ / __ __ __ __ and ending __ __ / __ __ / __ __ __ __

I certify that the above-named student is currently enrolled in this institution and based on school regulations is considered a full-time student.

☒_____

Signature of Registrar or Authorized Representative

Date __ __ / __ __ / __ __ __ __

School Seal

PART C *To be completed by Participant if your child is seeking continued coverage during a school recess*

I hereby certify that the above-named student will be attending _____(name of school) in the fall/spring term as a full-time student.

Participant's Signature: ☒_____
Date: _____.

PART D *To be completed by your child's treating physician if your child is seeking Disabled Student Coverage*

Physician's Name _____
Address _____
Phone Number _____

The above-named student has been under my care since:_____
Date of most recent medical examination: _____
Description of the student's medical condition:

_____
_____
_____.
Date of student's medical leave (or other change in enrollment):
Beginning Date: _____
Approximate End Date: _____

I hereby certify that: (i) the above-named student is suffering from a serious illness or injury; (ii) the student's leave of absence from (or other change in enrollment at) school is medically necessary; and (iii) the above information is true and complete.

☒_____
Signature of Treating Physician Date

SOUTHERN CALIFORNIA UNITED FOOD & COMMERCIAL WORKERS UNIONS AND DRUG EMPLOYERS TRUST FUNDS
2220 HYPERION AVENUE • LOS ANGELES, CALIFORNIA 90027
TEL (323) 666-8910 • FAX (323) 663-9495

Administrative offices for:

SOUTHERN CALIFORNIA UNITED FOOD & COMMERCIAL WORKERS UNIONS AND DRUG EMPLOYERS PENSION FUND

SOUTHERN CALIFORNIA DRUG BENEFIT FUND

Information About Disabled Student Coverage

The Southern California Drug Benefit Fund (the "Fund") provides continued Fund coverage to student dependents who, due to serious illness or injury, are no longer able to maintain full-time enrollment. This continued coverage will be referred to as "Disabled Student Coverage." **Please read this notice carefully; it explains Disabled Student Coverage and how it can become available to your child.**

Eligibility Requirements

To be eligible for Disabled Student Coverage, your child must satisfy all of the following requirements:

1. Your child must have been covered by the Fund as a "student dependent," as defined by the Fund, immediately before the first day of your child's leave of absence from (or change in enrollment at) school.

2. Your child must either: (i) take a leave of absence from school; or (ii) experience a change in enrollment at school that:
   a. Begins while your child is suffering from a serious illness or injury;
   b. Is medically necessary; AND
   c. Causes your child to lose "student dependent" status for purposes of coverage under the Fund.

Duration of Disabled Student Coverage

Disabled Student Coverage will terminate on the earlier of: (1) the last day of the month in which your child ceases to meet the requirements of 2, above; or (2) the date Fund coverage would otherwise terminate (e.g., when your child attains age 24).

How to Apply for Disabled Student Coverage

To apply for Disabled Student Coverage for your child, you must have your child's treating physician complete Part C of the Fund's Student Certification form (available from the Fund Office or your union local). You must also complete Part A of the Student Certification form and return it to the Fund Office within sixty (60) days of receiving the form. **To prevent confusion over the status of your child's coverage under the Fund, you are strongly encouraged to complete and submit the Student Certification form (Parts A and C) to the Fund Office as soon as possible.**

Questions?

If you have any questions regarding Disabled Student Coverage, please contact the Eligibility Department of the Fund Office at: Southern California Drug Benefit Fund, Attention: Eligibility Department, P.O. Box 27920, Los Feliz Station, Los Angeles, CA 90027, (323) 666-8910.