Cement Masons Health and Welfare Trust Fund for Northern California
4160 Dublin Blvd, Suite 400 Dublin, CA 94568 | Telephone: (707) 864-3300 or (888) 245-5005

APPLICATION FOR STUDENT EXTENDED DEPENDENT COVERAGE

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

PARTICIPANT'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

Participant'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.

Participant's Signature: Date: