PSEA Health & Welfare FUND

TO: Participants in the Dental and/or Vision Program(s)

FROM: PSEA Health & Welfare Fund

RE: **COVERAGE FOR FULL-TIME STUDENTS OF ELIGIBLE SUBSCRIBERS**

If your child is over age nineteen (19), but under age twenty-three (23), and enrolled as a full-time student in a school, college, or university, and primarily supported by you, the employee, coverage can be extended to that individual.

If your child qualifies for the extended coverage, please complete a Full-Time Student Certification form and have it certified by the Registrar of the school your child is attending. The school should be instructed to return the certified form to our office. You will receive a letter from the Health and Welfare Fund indicating the period of time that your dependent has been approved for coverage.

Upon receipt of the certification, coverage will be extended to eligible full-time students for a period not to exceed twelve (12) months. Recertification is required every twelve (12) months while the child is a full-time student. You should obtain a new form each time the extended coverage terminates until your child is no longer eligible as a full-time student. If you do not receive a form from the Health and Welfare Fund, you should obtain a form from your district office.

Except as provided for in the Plan's continuation of coverage provisions (COBRA), benefits terminate at the end of the month of the child's 19th birthday if your child is not enrolled as a full-time student.

If your child is not eligible for extended coverage as a full-time student, but would like to continue to participate in the dental and/or vision program(s) under the Plan's continuation of coverage provisions (COBRA), please notify our office that your child is not a full-time student. Upon receipt of your notification, we will provide your child with the necessary details, including costs, to continue participation in the dental and/or vision program(s).

Dental and vision claims for full-time students will be handled in the same manner as they are for you and other eligible dependents.

If you have any questions, please contact our office.

PSEA
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

NOTIFICATION OF INELIGIBLE DEPENDENT CHILD

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

(CHECK ONE – PLEASE READ CAREFULLY)

_____ Please be advised that my child has reached age 19 and is no longer eligible for dental, prescription, and/or vision coverage because he/she is not a full-time student.

_____ Please be advised that my child is no longer a full-time student. His/her last day as a full-time student was _____.

_____ Please be advised that my child has graduated from school and is no longer a full-time student. His/her graduation date was _____.

_____ Please be advised that my child continues to be a full-time student but has reached the age of 23.

Please provide me with the necessary details, including costs, to continue participation in the dental and/or vision program(s) under the Plan's continuation of coverage provisions (COBRA).

1. Employee's Name:

2. Employee's Social Security Number:

3. Home Address:

4. Employer of #1 above:

5. Child's Name:

PLEASE NOTE: THE EMPLOYEE OR A FAMILY MEMBER HAS THE RESPONSIBILITY TO INFORM THE PSEA HEALTH AND WELFARE FUND (PSEA-HWF) WHEN A DEPENDENT CEASES TO BE A "DEPENDENT CHILD." FAILURE TO INFORM PSEA-HWF WITHIN SIXTY (60) DAYS WILL RESULT IN THE INABILITY TO CONTINUE COVERAGE UNDER THE PROVISIONS OF COBRA.

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