

McKenzie & Company

Employee Benefits Advisors

NON-UNIT STUDENT CERTIFICATION FORM

Thank you for selecting the Non-Unit Health & Welfare Fund Dental Plan. Your family membership provides coverage for full-time students to age 25. Please complete the following information so that we can continue to provide coverage for your son or daughter while he or she is a student.

Student's Name: _____

Student's Social Security Number: _____

Student's Date of Birth: _____

Effective Date of School Enrollment: _____

Name of School: _____

Subscriber's Name: _____

Subscriber's Dental Plan ID Number: _____
(usually your Social Security #)

Subscriber's Signature

Date

Please return completed form to:

***McKenzie & Company
P.O. Box 6239
John F. Kennedy Station
Boston, MA 02114-0015***

Please have this form stamped by the school Registrar's Office or attach a copy of your child's paid tuition bill.

_____ is enrolled as a full-time Student.

School Certification (stamp)