

BEVERAGE DRIVERS HEALTH AND WELFARE TRUST FUNDS

Fund Office: GEMGroup, Administrator, The Constellation Centre One, 6009 Oxon Hill Road, Suite 416, Oxon Hill, MD 20745
Phone: (301) 839-8800 / 1-800-424-2707 / Fax: (301) 839-8812

Dear Mr.

This letter is to advise that your group health insurance coverage for your Student Dependent, _____ is to be terminated effective _____

For verification that _____ is a full-time student, please complete the form at the bottom of this letter and return it to the Fund Office in the enclosed envelope.

If your child is not a full-time student, replacement coverage is available under the COBRA provisions offered by the Fund. You will receive COBRA information after the benefit termination date of _____.

Should you have any questions, please contact the Fund Office at the above listed phone numbers.

Student Verification Application

Dependent Name:

Dependent SSN:

Dependent Birth Date:

School/College _____

Campus _____

Current School Year: _____

Expected Date of Graduation: _____

I, the undersigned, certify that the above named dependent is a full-time student, unmarried, and dependent upon me under the applicable rules and regulation of the Internal Revenue Service and whose legal residence is the same as mine.

Member Signature: _____ Date Signed _____

YOU MUST INCLUDE A COPY OF YOUR DEPENDENT'S CLASS SCHEDULE OR A PAID TUITION RECEIPT AS VERIFICATION OF STUDENT ENROLLMENT.

Yours very truly,

Board of Trustees