Dear UUP Benefit Trust Fund Participant:

Do you have a dependent listed on your UUP Benefit Trust Fund (Fund) file who is age 19 or older? To qualify for coverage under the Fund, dependents between ages 19 and 25 must attend school full-time (at least 12 credit hours; 9 credit hours for graduate work) and must be an unmarried dependent for income tax purposes. Full-time students are eligible until the end of the month in which they attain 25 years of age, or cease to be a full-time student, whichever occurs first. Graduating dependents with documentation are eligible for three months of continued Fund coverage following the end of the month in which they complete course requirements for graduation.

The insurance carriers of the Fund require confirmation of your child’s student status. This information will be conveyed to CIGNA Dental and Davis Vision to be used for eligibility verification. This information will not be conveyed to the Empire Plan, an HMO or prescription drug carriers. You must send separate student verification to those carriers individually.

Dental and vision claims for your dependent(s) between ages 19 and 25 will not be paid until verification of their full-time student status is received. To do this, please complete the form on the following page, have it notarized and return it to the UUP Benefit Trust Fund at PO Box 15143, Albany, NY 12212-5143. If it is easier for you to provide student verification in another format, it must include the member’s name and social security number (optional), the student’s name and social security number (optional), the name of the school and indicate full-time status or total course credits being taken.

If your child has graduated or does not qualify for coverage under the Fund, he or she may qualify for COBRA Continuation Coverage. It is the responsibility of the member or dependent to contact the Fund Office to request COBRA within 60 days of a dependent’s coverage ending. After the 60-day period, that dependent will not be able to continue coverage.

If your eligible dependent is an undergraduate student earning 12 or more credit hours at a state-operated SUNY school they may qualify for a $500 scholarship from the Fund. Call the Fund Office for details.

If you have any questions, please contact the UUP Benefit Trust Fund Office at 800-UUP-FUND (800-887-3863).

Sincerely,

UUP Benefit Trust Fund

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**TRUSTEES**

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<thead>
<tr>
<th>Chair</th>
<th>Secretary</th>
<th>Administrator</th>
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<tbody>
<tr>
<td>William E. Scheuerman</td>
<td>Eileen Landy</td>
<td>Doreen M. Bango</td>
</tr>
<tr>
<td>Rowena J. Blackman-Stroud</td>
<td>Frederick G. Floss</td>
<td>John J. Marino</td>
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<tr>
<td>Trustee</td>
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<td>Trustee</td>
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</tbody>
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Revised 01/22/07
Return this form to
UUP Benefit Trust Fund
P.O. Box 15143
Albany, NY 12212-5143
800-887-3863 or 800-UUP-FUND
Fax 866-559-0516

Student Verification Form

Date: _____/_____/_____

Member Name: ________________________________ SS # (Optional): ______-_______

Address: ________________________________ Telephone #: Home (____) ______

______________________________ Work (____) ______

The information below must be provided before coverage can continue for your dependent children ages 19 to 25.

Dependent Name: ________________________________ Dependent SS #: ______-_______
(Optional)

Dependent Birth Date: _____/_____/_____

Student Status

__ Dependent is currently a student. Complete steps (1-4) below.

(1) Currently enrolled as:

□ Part-time student or □ Full time student (12 credit hours)
(9 credit hours for graduate work)

(2) Check all that apply:

□ Spring Semester 2006 □ Fall Semester 2006

□ Spring Semester 2007 □ Fall Semester 2007

(3) Anticipated Graduation Date: _____/_____/_____

(4) School Information:

Name of School: ____________________________________________

School Address: ____________________________________________

Is this a SUNY School? (Circle one) Yes or No

__ Dependent has graduated and is no longer eligible for UUP Benefit Trust Fund coverage.

Graduation Date: _____/_____/_____

__ Dependent is not returning to school. Last date student was enrolled: _____/_____/_____

Any person who knowingly and with intent to defraud, or conceals information concerning any fact material, commits a fraudulent insurance act, which is a crime, and shall be subject to penalty and retroactive termination of coverage.

Member Signature ________________________________ Date: _____/_____/_____

On this ______ day of ____________, before me came ______________________, being dually sworn and to me known to be the individual described in and who executed the foregoing instrument and acknowledged that (s)he executed the same.

Notary Signature ________________________________ Date: _____/_____/_____

Notary Seal

Revised 01/22/07