COLLEGE OF THE SISKIYOUS
HUMAN RESOURCES

TO:

Insured Name ____________________________Insured Social Security Number___________________

RE: Dependent Student Status

Dependent _______________Relationship _________________ Date of Birth _____________________

Coverage for dependent children ceases on their 19th birthday, unless they are full-time students.

If your dependent qualifies, please obtain a letter on school letterhead, including all the information requested below, bearing the registrar's signature and the school's embossed seal; **OR** have the school complete this form in full with embossed seal. Submit original to address below.

This is to certify that _______________________ _________ _______________________________is a
(Dependent name) (Social Security Number)

full-time ______ part-time _____student at ____
(School name)

____
(School address and telephone number)

which is a ________________________________, taking _______ units for the
(Type of school)

quarter _______ semester ____________, beginning __________ and ending __________

BY _______________________________ DATE_________ TITLE ____________________________
(Authorized signature)

THIS FORM IS NOT VALID WITHOUT THE EMBOSSED SCHOOL SEAL. INCOMPLETE INFORMATION WILL CAUSE A DELAY IN YOUR CHILD'S ELIGIBILITY FOR BENEFITS.

Please return to:

COLLEGE OF THE SISKIYOUS
HUMAN RESOURCES
800 COLLEGE AVENUE
WEED CA 96094