

**T**RANSPORTATION • **C**OMMUNICATIONS • **I**NTERNATIONAL **U**NION  
LOS ANGELES METROPOLITAN TRANSPORTATION AUTHORITY  
HEALTH & WELFARE TRUST FUND  
13191 Crossroads Parkway North, #205, City of Industry, California 91746-3434  
(562) 463-5090 (800) 427-5342

**VERIFICATION OF FULL-TIME STUDENT STATUS**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ DATE \_\_\_\_\_

Based upon your dependent, \_\_\_\_\_'s age, coverage under our Group Plan is contingent upon full-time attendance in an accredited College, University or comparable educational institution. In order that we are properly informed, please sign the authorization for release of information below and forward this form to the school attended by this dependent. Claims for group insurance benefits cannot be processed further until this completed form is returned.

TO: \_\_\_\_\_  
(Name of College or University)

This authorizes you to release the information requested below relative to the status of dependent,  
\_\_\_\_\_.

\_\_\_\_\_  
(Student's Signature) (Employee's Signature)

**(PLEASE FORWARD TO THE APPROPRIATE COLLEGE OR UNIVERSITY)**

Is (or was) \_\_\_\_\_ a full-time student during the \_\_\_\_\_  
20 \_\_\_\_\_ quarter/semester? Yes \_\_\_\_\_ No \_\_\_\_\_. If the school term was not completed, please indicate the  
date attendance ceased \_\_\_\_\_. Enrollment is (or was) for \_\_\_\_\_ units.  
Requirement for full-time status is \_\_\_\_\_ units.

Signed \_\_\_\_\_

Title \_\_\_\_\_

Date \_\_\_\_\_

Address \_\_\_\_\_

**(PLEASE RETURN FORM TO THE ADMINISTRATIVE OFFICE)**