



AFTRA HEALTH PLAN FULL-TIME STUDENT VERIFICATION FORM

INSTRUCTIONS

Unmarried children over age 21 who are chiefly dependent upon you for support and maintenance may continue to qualify for coverage under the AFTRA Health Plan (the Plan) if they are attending school or college as full-time students. This extended qualification can continue until the date the children lose their full-time student status, or the end of the calendar year in which they turn 23, whichever is earlier.

To enroll your unmarried dependent child in the Plan claiming full-time student status, at the start of each semester you must complete this form and submit it to the Eligibility Department in the AFTRA Health & Retirement Funds (AFTRA H&R) New York office, along with acceptable proof from the school or college to confirm that your child is enrolled as a full-time student for the current semester. Acceptable proof from a school or college includes:

1. A letter verifying that your child is enrolled as a full-time student for the current semester from an appropriate office (e.g., Bursar's office or Admissions office) or official (e.g., Dean);
2. A printed receipt verifying that your child is enrolled as a full-time student for the current semester and the tuition has been paid in full; or,
3. A "paid-in-full" registration course schedule verifying that your child is enrolled for a sufficient number of credits to be considered a full-time student for the current semester.

The Eligibility Department must receive your original completed form and acceptable proof of enrollment no later than January 1 for the Spring semester and no later than October 1 for the Fall semester.

The Eligibility Department is located at:

AFTRA Health & Retirement Funds
Attention: Eligibility Department
261 Madison Avenue
New York, New York 10016

REMEMBER TO KEEP A COPY OF YOUR COMPLETED FULL-TIME STUDENT VERIFICATION FORM AND THE PROOF OF ENROLLMENT PROVIDED BY THE SCHOOL OR COLLEGE FOR FUTURE REFERENCE.

To learn more about AFTRA H&R's written notice and documentation requirements regarding life events and qualification for coverage under the Plan, visit our Web site at www.aftrahr.com, or call Participant Services at (800) 562-4690.

TO BE COMPLETED BY THE ENROLLED PARTICIPANT

Section I: Participant Information

Participant Name	Participant Social Security Number
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Participant Mailing Address

Section II: Student Information

Student Name	Student Social Security Number
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Student Date of Birth	Student's Relationship to Participant
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Section III: School or College Information

School or College Name	Semester	Credits/Units
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Enrollment Period	Anticipated	Graduation Date
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School or College Address

School Contact Person	School Contact Person's Phone Number
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Section IV: Declaration and Certification

I certify that my unmarried child is chiefly dependent upon me for support and maintenance and is a full-time student as defined on pages 7-8 of the AFTRA Health Plan's Summary Plan Description (SPD), January 2005 edition, and its amendments. I understand that: a) I must notify the Eligibility Department in the AFTRA H&R New York office immediately in writing if my child marries, graduates, or is no longer considered a full-time student; b) my child may have a right to continuation coverage under COBRA (the Consolidated Omnibus Reconciliation Act) when he or she no longer qualifies as a dependent; and, c) I must notify the Eligibility Department in the AFTRA H&R New York office within 60 days of the date my child loses coverage as a dependent under the Plan (i.e., the qualifying event) to exercise the right to continuation coverage under COBRA.

I further certify that all the information provided on this form and in any attached documents is accurate and complete, and I understand that providing misinformation to the Plan may result in the denial, suspension or discontinuance of benefits for me and my dependents. I also acknowledge that the Plan reserves the right to recover any health claim overpayments that result from misinformation provided on this form or its attachments.

Participant Signature	Date
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