

**Union Construction Workers Health Plan**  
**P. O. Box 697**  
**Toledo, Ohio 43697-0697**

**419 248-2401**

Please complete this form and attach a copy of your present schedule and return it to the Fund office as soon as possible.

Employee Name.....SS#.....  
Dependent's Name.....  
Date of Birth.....  
Name of School or University .....

Hours for which Enrolled.....	Quarter.....	Semester.....
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Full Time Student.....Part Time Student.....  
Year Expected to Graduate (approximate).....  
Depends Fully on My Support.....Yes.....No.....  
Dependent's Social Security #.....  
Is Dependent Covered by Another Insurance?.....Yes.....No.....

I Certify That This Information is Correct

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Dean/Advisor Signature

\_\_\_\_\_  
Date