



UNITED UNIVERSITY PROFESSIONS
BENEFIT TRUST FUND
P.O. Box 15143
Albany, NY 12212-5143

800-UUP-FUND
800-887-3863
Fax 866-559-0516
www.uupinfo.org
benefits@uupmail.org

DENTAL & VISION STUDENT VERIFICATION Fall 2008 & Spring 2009

Your unmarried dependent children, ages 19 through 25, are eligible for dental and vision benefits through the UUP Benefit Trust Fund (Fund) if they are full-time (12 undergraduate credits or 9 graduate credits) students at an accredited secondary school or college. Dependent students continue to be eligible until the first of the following events occurs:

- The end of the month in which they cease to be a full-time student; or
- The end of the month in which they reach age 25; or
- The end of the third month following the month in which they complete graduation requirements

The dental and vision insurance carriers of the Fund require confirmation of your dependent children's student status for eligibility verification. Dental and vision claims for your dependent children between ages 19 and 25 will not be paid until verification of their full-time student status is received by the Fund.

Please complete the Student Verification Form on the opposite page, **have it notarized** and return it to the UUP Benefit Trust Fund at P.O. 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 ID number; the student's name, date of birth, and ID number; student status; semester(s) covered; and the name of the school.

Student verification information will not be transmitted to the Empire Plan, HMOs, or prescription drug carriers. You must send separate student verification to these carriers.

If your dependent child has graduated or does not qualify for coverage under the Fund, they may qualify for Continuation of Coverage for Dental and Vision (COBRA) for up to 36 months. It is the responsibility of the member or dependent child to contact the Fund to request COBRA no later than 60 days from the coverage termination date. After the 60-day period, the dependent child will not be able to continue coverage.

Also, if your dependent child is an undergraduate student earning 12 or more credit hours at a state-operated SUNY school they may qualify for a \$750 scholarship from the FUND.

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

TRUSTEES

Phillip H. Smith, Chair Eileen Landy, Secretary Doreen M. Bango, Administrator
Rowena J. Blackman-Stroud, Trustee Frederick G. Floss, Trustee John J. Marino, Trustee Edward H. Quinn, Trustee

UUP Benefit Trust Fund

P.O. Box 15143
Albany, NY 12212-5143

Student Verification Form

Member Name: _____ Member ID Number* : _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Dependent Name: _____ Dependent Date of Birth: _____

Dependent Social Security Number (Optional): _____

* *Your Member ID number can be found on your NYSUT Membership Card, your Delta Dental Card, or your Davis Vision Card. The number is the same on all three cards.*

A. Dependent is currently a student. Complete steps 1-4 below.

(1) Currently enrolled (check one): Full-time undergraduate student (12 credit hours)

Graduate student (9 credit hours)

Full-time high school student

(2) Check appropriate semester(s): Fall Semester 2008 (eligibility through 3/31/09)

Spring Semester 2009 (eligibility through 9/30/09)

(3) Name of school: _____

(4) Anticipated graduation date: ____/____/____

B. Dependent is currently NOT a student. Complete steps 5 or 6 below.

(5) Dependent has graduated and is no longer eligible. Graduation date: ____/____/____

(6) 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 duly 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