BETHPAGE CONGRESS OF TEACHERS BENEFIT TRUST
DEPENDENT STUDENT VERIFICATION FORM

Dear Member:

A Student Verification Form must be filed for during the **FALL** semester each year. In order to consider your dependent child, who is between 19 and 25 years of age, for benefits under the BETHPAGE CONGRESS OF TEACHERS BENEFITS TRUST Dental Program, please complete Section I and forward to the Registrar/Bursar's office for the completion and submission to:

Administrative Services Only, Inc.
PO Box 9005,
Lynbrook, NY 11563-9005.

SECTION I TO BE COMPLETED BY MEMBER

MEMBER NAME: _____ **SOC. SEC. NO** ☐☐☐-☐☐-☐☐☐☐
(LAST NAME) (FIRST NAME)

STUDENT NAME: _____ **SOC. SEC. NO** ☐☐☐-☐☐-☐☐☐☐
(LAST NAME) (FIRST NAME)

DATE OF BIRTH ☐☐-☐☐-☐☐

I certify that my dependent meets all of the following criteria for eligibility as a dependent student:

	YES	NO
A. Dependent is between 19 and 25 Years of age.	☐	☐
B. Unmarried	☐	☐
C. Is a full-time student in at an accredited educational institution	☐	☐

I agree to advise THE BETHPAGE CONGRESS OF TEACHERS BENEFIT TRUST promptly of any changes in my child's dependent student status.

MEMBERS SIGNATURE:_____ **DATE:**_____/_____/_____

SECTION II ATTACH REGISTRAR'S/BURSAR'S LETTER OR HAVE THE FORM COMPLETED BY THE ACCREDITED EDUCATIONAL INSTITUTION

NAME OF SCHOOL:_____ **IS ACCREDITED** ☐ **YES** ☐ **NO**

I CONFIRM THAT_____ **(student name)**

IS REGISTERED AS A: ☐ **FULL-TIME OR** ☐ **PART-TIME STUDENT**

FOR THE: ☐ **FALL SEMESTER** _____ **NUMBER OF CREDITS TAKEN FOR SEMESTER**

WHICH BEGINS ON ☐☐/☐☐/☐☐ **AND ENDS ON** ☐☐/☐☐/☐☐

MAIL VALIDATED FORM TO:

ADMINISTRATIVE SERVICES ONLY, INC.
PO BOX 9005
LYNBROOK, NY 11563-9005

AFFIX INSTITUTION SEAL HERE

_____ _____/_____/_____
AUTHORIZED SIGNATURE OF REGISTRAR OR BURSAR **DATE**