Washingtonville Benefit Trust Fund

c/o Zenith American Solutions
PO Box 5817
Wallingford, CT 06492-7617
(800) 827-1703
Fax: (203) 284-8656

Date: _____ Group: 613

Employee: _____

Student: _____

Dear Registrar:

Our office requires verification that the above-named dependent is/was enrolled as a full-time student as _____ (name of school).

Please confirm this dependent's status below to verify his/her eligibility for benefits. Please check appropriate status and semester and fill in the year.

____ Full time student, FALL _____ Semester credits are/were _____

____ Full time student, SPRING _____ Semester credits are/were _____

____ Part-time student, FALL _____ Semester credits are/were _____

____ Part-time student, SPRING _____ Semester credits are/were _____

Date of graduation or anticipated date of graduation: _____ / _____
(month) (year)

Additional comments: _____

_____

To insure proper identification, please return this request to the above address. Thank you for your cooperation.

_____
Signature / Seal of Registrar
Date: _____