



**Faculty Association of Suffolk Community College
Benefit Fund**
533 College Road, Southampton Bldg., Room 224-D
Selden, NY 11784-2899
631-732-6500

STUDENT VERIFICATION FORM

Member Complete

Member Name _____ Member SS# _____

Address _____

City _____ State _____ Zip Code _____

Dependent Student Name _____

Dependent Student SS# _____

_____ This dependent has graduated and is no longer eligible. Graduation Date: _____

_____ This dependent is not returning to school.

_____ This dependent is currently a student. (School must complete section below).

_____ My son/daughter intends to enroll full-time in the: Spring _____ Fall _____ 20 _____ Semester.

I certify that the above information is true and accurate.

Member's Signature _____ **Date** _____

School Complete

Dear Registrar:

We are verifying the status of this student in order to determine eligibility for benefits. Your prompt response to the following would be greatly appreciated and will prevent any interruption in coverage.

This is to verify that the above-named student is currently enrolled as a full-time student as follows:

FALL 20 _____ for _____ semester hours of: undergraduate _____ graduate _____ courses.

SPRING 20 _____ for _____ semester hours of: undergraduate _____ graduate _____ courses.

SUMMER 20 _____ for _____ semester hours of: undergraduate _____ graduate _____ courses.

Signature of Registrar _____ Date _____

Title _____

Name of School _____

City _____ State _____ Zip Code _____

Telephone () _____

Please return to the above address.

