



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

Your unmarried dependent children who are age 19 or over but under age 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 or preparatory school, college or other educational institution and are otherwise not eligible for employer group coverage. They continue to be eligible until the earlier of the following dates:

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

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.

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

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### TRUSTEES

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

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# 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 2011 (eligibility through 3/31/12)  
 Spring Semester 2012 (eligibility through 9/30/12)
- (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