

# Carpenters Health and Security Plan of Western Washington

PO Box 1929 Seattle WA 98111

## Student Questionnaire – Summer

Participant's name: \_\_\_\_\_ Member #: \_\_\_\_\_

Student's name: \_\_\_\_\_

1. Did this child attend school on a full-time basis during the prior spring quarter?  Yes  No. If yes, at which school? \_\_\_\_\_
2. Will this child attend school on a full-time basis during the upcoming fall quarter?  
 Yes  No. If yes, at which school? \_\_\_\_\_
3. Is this child married?  Yes  No. If yes, what is the marriage date? \_\_\_\_\_
4. Is this child employed?  Yes  No. If yes, what is the name of the employer?  
\_\_\_\_\_

Is health care coverage provided by the employer?  Yes  No. If yes, what is the name and address of the health care plan? \_\_\_\_\_

What type of coverage is provided?  Medical  Dental  Vision  Prescription

5. Does this child claim himself or herself on his or her own federal income tax return?  
 Yes  No. If no, why not? \_\_\_\_\_
6. Is this child covered under another health care plan other than the plan indicated above?  
 Yes  No. If yes, what is the name and social security number of the insured?  
\_\_\_\_\_

What type of coverage is provided?  Medical  Dental  Vision  Prescription

7. Is this child living with you?  Yes  No. If no, where and with whom does this child live?  
\_\_\_\_\_
8. Is this child primarily dependent on you for support and maintenance?  Yes  No. If yes, please explain in detail how this child is primarily dependent on you for support and maintenance:  
\_\_\_\_\_  
\_\_\_\_\_

Is this child claimed as an exemption on your federal income tax return?  Yes  No. If no, why not? \_\_\_\_\_

I hereby certify that the foregoing statements are true, correct, and complete to the best of my knowledge. I will inform the Trust Office as soon as a child no longer meets the eligibility requirements of the Carpenters Health and Security Plan. **Important:** During the first three weeks of a quarter or semester, student eligibility is generally not available from Student Clearinghouse. If the student needs his or her eligibility updated for a covered service, supply, or prescription during the first three weeks of a quarter or semester, you **must** send us a copy of his or her class schedule so we can provide temporary eligibility.

\_\_\_\_\_  
Participant's Signature

\_\_\_\_\_  
Date