PUTNAM VALLEY FEDERATION OF TEACHERS WELFARE FUND
INSURANCE PROGRAMMERS, INC.
POST OFFICE BOX 5817
WALLINGFORD, CONNECTICUT 06492

DATE:____________________ GROUP NO: 33

EMPLOYEE NAME: ____________________

EMPLOYEE SSN: ____________________

DEPENDENT NAME: ____________________

DEPENDENT SS#: ____________________

Dear Registrar:

Our office requires verification that the above named dependent is/was enrolled as a full-time student at ____________________
Name of School

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

____________ FULL TIME STUDENT ____________ SPRING SEMESTER
____________ PART TIME STUDENT ____________ FALL SEMESTER
____________ #SEMESTER CREDITS ____________ YEAR

DATE (OR ANTICIPATED DATE) OF GRADUATION ________ ________
Month Year

ADDITIONAL COMMENTS: ____________________

Please return this request to:
Putnam Valley Central School District
146 Peekskill Hollow Road
Putnam Valley, NY 10579
Att: Debbie Monteferante

____
Signature/Seal of Registrar

Thank you for your cooperation

____
Date