

TO:

FROM:  
**ILA EMPLOYERS WELFARE FUND**

510 West Bryan Street  
P.O. Box 1280  
Savannah, Georgia 31498-1280  
Telephone: 912-233-0218  
Fax: 912-233-5195

Insured's Name \_\_\_\_\_ SS# \_\_\_\_\_ Date \_\_\_\_\_

Dependent's Name \_\_\_\_\_

MESSAGE

So that we can determine eligibility under the MILA Managed Health Care Trust Fund Group Insurance Plan and the ILA Employers Welfare Fund named above, we must have information from the above dependent child's school.

Please have your child sign and date the form below and take this to the Records Office of his/her school. If your child is under 18, we will also require a parent's signature. The Records Office should then fully complete the remainder of the form and return it to the address shown above.

Thank you for your assistance.

Sincerely,

(MRS.) VIRGINIA M. PARHAM  
Fund Manager

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**For Completion by Student and Insured**  
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I hereby authorize the release to and use by MILA Managed Health Care Trust Fund and the ILA Employers Welfare Fund any student information needed to process my claim(s).

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent's Signature if child is under 18

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student's I.D. or S.S. Number

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**For Completion by School's Records Office**  
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Is the above named dependent a full-time student? [ ] Yes [ ] No

If "yes", we need to know:

Initial Enrollment Date	Inclusive Enrollment Dates	Current Year Semester/Quarter	Current Units Enrolled	Total Units Completed
_____	_____	_____	_____	_____

How many units qualify a student as "Full Time"? \_\_\_\_\_

If "no", we need to know:

Semester/Quarter/Year Last Enrolled	Inclusive Enrollment Dates
_____	_____

Is student enrolled in a course of study leading to (check one):

[ ] Academic Degree [ ] Diploma [ ] Certificate

Name of School \_\_\_\_\_

\_\_\_\_\_  
Authorized Signature and Title of School Official

\_\_\_\_\_  
Date

SCHOOL'S SEAL

**SCHOOL VERIFICATION FORM**