MAMARONECK TEACHERS' ASSOCIATION
HPA div of INSURANCE PROGRAMMERS INC.
P.O. BOX 5817
WALLINGFORD, CT 06492

DATE:_____ GROUP NO: 14

Employee:_____ Employee's SSN:_____

Dependent:_____

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 appropriate status and semester and fill in the year.

_____Full time student, Fall_____. Semester credits are/were_____

_____Full time student, Spring_____. Semester credits are/were_____

_____Part-time student, Fall_____. Semester credits are/were_____

_____Part-time student, Spring_____. Semester credits are/were_____

Date of graduation or anticipated date of graduation: _____./_____
(month) (year)

Additional Comments: _____

To insure proper identification, please return this request to the above address.
Thank you for your cooperation.

Signature/Seal of Registrar Date