

**MONTGOMERY COUNTY EMPLOYEE BENEFIT PLAN  
DEPENDENT STUDENT STATEMENT**

Group Number: #248 Active Employee

**Employee's Name:** \_\_\_\_\_  
**Employee's SS #** \_\_\_\_\_ -XX- \_\_\_\_\_

**Please complete the following information and forward to college/university:**

- A. I certify that \_\_\_\_\_ Social Security # \_\_\_\_\_ - XX - \_\_\_\_\_ is \_\_\_\_\_ years of age, is unmarried and dependent on me for support. He/She is a full-time student, as defined in the Montgomery County Employee Benefit Plan and enrolled in the following institution.  
Institution: \_\_\_\_\_  
Address: \_\_\_\_\_  
Registrar's Phone #: \_\_\_\_\_

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*Signature of Employee* \_\_\_\_\_ *Date* \_\_\_\_\_

- B. As the student listed above, I authorize the said institution to release any information regarding my enrollment.

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*Signature of Student* \_\_\_\_\_ *Date* \_\_\_\_\_

**C. TO BE COMPLETED BY COLLEGE / UNIVERSITY:**

PLEASE COMPLETE THE FOLLOWING INFORMATION ON THE STUDENT LISTED ABOVE AND RETURN TO THE ADDRESS BELOW:

The student listed above is enrolled as a full-time student for (circle one) Spring / Fall Semester of 20\_\_\_\_ to 20\_\_\_\_. Number of hours enrolled: \_\_\_\_\_.

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*Signature* \_\_\_\_\_ *Title* \_\_\_\_\_ *Date* \_\_\_\_\_

\_\_\_\_\_  
*Phone #*

**MONTGOMERY COUNTY RISK MANAGEMENT DEPARTMENT  
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Phone 936/760-6935 Fax 936/760-6916**