

**ILWU-PMA COASTWISE CLAIMS OFFICE**

814 Mission Street, Suite 300  
San Francisco, CA 94103

Tel: 800-955-7376 or 415-543-0114

Fax: 415-495-0511

Date: \_\_\_\_\_

Participant: \_\_\_\_\_

Dependent: \_\_\_\_\_

Plan No: **6475** \_\_\_\_\_

SS# or Registration #: \_\_\_\_\_

Dear: \_\_\_\_\_

In order to process the claim you recently submitted for this dependent child, we find that additional information is needed. Please have the Statement of Enrollment provided below completed by the registrar of the school which is the child now attending. The fully completed form should be returned to our office as soon as possible so that we may proceed with the processing of this claim.

Thank you,

CLAIMS

STATEMENT OF ENROLLMENT

This is to certify that \_\_\_\_\_ is enrolled at:  
(name of student)  
\_\_\_\_\_ for the  
\_\_\_\_\_ (semester) (quarter)  
(Fall, Winter, Spring, Summer)

Which began on \_\_\_\_\_ and will end on \_\_\_\_\_.  
(date) (date)

This student is enrolled for \_\_\_\_\_ units of course work, which (does)  
(does not) constitute full time attendance at this institution.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_  
(Registrar)