Education Assistance Request
For Dependents of Faculty & Staff

Please complete this form and return it to Human Resources. A description of this benefit is in the Employee Benefit section of the Employee and Faculty Handbooks, and included below and at

http://www.westmont.edu/_faculty_staff/pages/employment/pages/on-campus/employee_handbook/6_11edassistance.html

As part of my application for dependent education assistance, I certify that the dependent child named on this form meets all the IRS guidelines for dependent status. (If you are unsure of meeting the IRS guidelines, contact them.)

My eligible_________________________ will be taking _______ units during the

_________________________ son/daughter semester, and the credits for these units will be applied

Fall/Spring/MayTerm toward a bachelor’s degree. This will be semester number ______ of the eight semesters my child is eligible for this benefit.

My dependent’s name is:__________________________________________________
(please print)    Last    First

My name is:_____________________________________________________________
(please print)    Last    First

Date:____________________________________

Financial Aid requirement met:____________________________________________

___________________________________________  Date:_______________________
Director of Financial Aid

Amount of Assistance_______________% Date Eligible___________________

________________________________________________________  Human Resources
Processed By:____________________________________________ Business Office

Date:________________________________
REQUEST FOR WAIVER OF HEALTH FEE

Student’s Name__________________________________________________________

Last      First

Relationship: _____Spouse  _____Dependent Date:___________________

Because the above-named dependent is covered under one of Westmont College’s employee group medical plans, I request that he/she be excused from the Westmont College Student Health Plan and that the health fee be waived for the Semester of Fall/Spring (circle one) 20____. I further understand that it is my dependent’s responsibility to notify the staff of Health Services of this fact prior to receiving any medical services to ensure the appropriate coordination of insurance coverage.

___________________________________    __________________________________
Employee’s Name       Employee’s Signature

__________       cc:  Health Center
Human Resources Verification       Student Accounts

Student Accounts