



AMERICAN MARITIME OFFICERS (AMO) PLANS

2 West Dixie Highway, Dania Beach, FL 33004
Tel: (954) 920-4247 (800) 348-6515 Fax: (954) 920-9482 www.amoplans.com
email: amomedical@amoplans.com

For AMO Official Use Only

Received Date: _____

Received By: _____

APPLICATION FOR SCHOLARSHIP BENEFIT

The American Maritime Officers Medical Plan provides all eligible Covered Participants with yearly scholarship benefits for each dependent child maintaining a passing average 2.0 G.P.A. as a full-time student (24 credits a scholastic year) in an accredited college or trade school (four years of undergraduate study or the equivalent). To be eligible for the benefit, the Covered Participant must be eligible for medical benefits from American Maritime Officers Medical Plan both on the date the dependent student registers and the date the scholastic year ends. Also, the Covered Participant must be employed by a company whose contributions to the Medical Plan include funds for the scholarship benefit both on the student's date of registration and the date the scholastic year ends.

The term "Dependent Student" shall mean each unmarried child who is nineteen years but less than twenty-three years of age provided such child is attending school on a full-time basis and is dependent the Participant for principal support and maintenance. School vacation periods during any calendar year which interrupt but do not terminate what otherwise would have been a continuous course of study in that calendar year shall be considered a part of school attendance on a full time basis. Full-time shall mean the completion of twelve (12) credit hours per semester or its equivalent. Credits completed during summer or winter sessions may be applied to any one semester in a scholastic year. **The term "Child" shall include**, a legally adopted child, a step-child who has been a member of the Participant's household and dependent upon him for support, or a foster child or a child under legal guardianship who is a member of the Participant's household.

PARTICIPANT INFORMATION

Participant's Name:	SSN: XXX-XX-	Book Number:
Street Address:		
City:	State:	ZIP Code:
Home Telephone No.:	Cellular Phone No.:	

DEPENDENT STUDENT INFORMATION

Dependent Student's Name:	SSN: XXX-XX-	DOB:	
Name of College:	School Telephone No.:		
Address of College:	City:	State:	ZIP Code:
Entrance Date:	Expected Graduation Date:	Years Completed:	

The AMO Medical Plan Rules and Regulations require that each dependent child maintain a passing average 2.0 G.P.A. as a full-time student (24 credits a scholastic year), to be eligible for the scholarship benefit. Please indicate below the scholastic semesters for which you are applying for the yearly scholarship benefit:

2010 Calendar Year	<input type="checkbox"/> Spring Semester	<input type="checkbox"/> Summer Semester	<input type="checkbox"/> Fall Semester	<input type="checkbox"/> Winter Semester
2011 Calendar Year	<input type="checkbox"/> Spring Semester	<input type="checkbox"/> Summer Semester	<input type="checkbox"/> Fall Semester	<input type="checkbox"/> Winter Semester
2012 Calendar Year	<input type="checkbox"/> Spring Semester	<input type="checkbox"/> Summer Semester	<input type="checkbox"/> Fall Semester	<input type="checkbox"/> Winter Semester

Attach copy of official transcript to this form and mail it to American Maritime Officers Scholarship Benefit,
P.O. Box 35, Dania Beach, FL 33004

DEPENDENT AFFIDAVIT

I hereby attest that _____, my son/daughter/ stepson/ stepdaughter, is dependent upon me to provide the major portion of his/her support. I further attest that this child meets the definition of the dependent as summarized below. I hereby certify that the information contained herein is true. I understand that if I make false statement and collect money fraudulently from the American Maritime Officers Medical Plan, I am liable to expulsion from the Union in accordance with the terms of the constitution.

SIGNATURES

Participant Signature:	Date:
------------------------	-------

NOTARY PUBLIC

STATE OF _____)
COUNTY OF _____)

The foregoing instrument was acknowledged this _____ day of _____, 20____, by _____ (print name of participant), who personally appeared before me and acknowledged that he/she signed the instrument voluntarily for the purpose expressed in it.

Signature of Notary Public _____ Print, Type, or Stamp Commissioned Name of Notary Public _____ Date Commission Expires _____	NOTARY SEAL	<input type="checkbox"/> Personally Known <input type="checkbox"/> Produced Identification Type of Identification: _____
--	-------------	--