ACADEMIC SCHOLARSHIP APPLICATION

Applicant's Name ____

Applicant's Address ____
Street City State Zip

Applicant's Email _______________________________ **Telephone Number** ________________________

I. Please tell us about your affiliation with AG HEALTH BENEFITS ALLIANCE:

Name of the group health plan member?____

Name of employer: ____

Please circle your relationship to the member and provide the applicable date:

Self	Date of Birth _______________
Spouse	Date of Marriage_____________
Child (under age 25)	Date of Birth ________________
Grandchild (under age 25)	Date of Birth ________________

Health Care Identification Number (HCID): **W00 -** _ _ **-** _ _ _ _ *(this number is located on the health care ID card)*

II. Please tell us about your educational goals and situation:

1. What do you intend to study?____
2. What are your intended post-education plans?

____

3. Are you currently a student?

High School Name: ____

College/ University Name: ____

First Choice School:_________________________________ Status: _______________

Annual Tuition: ____________ Housing: ____________ Other Expenses: ____________

Please Explain: ____

____

____

Second Choice School: ____ Status: _______________

Annual Tuition: _______________ Housing: _______________ Other Expenses: _______________

Please Explain:____

____

____

III. How will your education be funded? Check all that apply.

1.

____ FAFSA, Amount: ____________ Status: ____________

____ Pell Grant, Amount: ____________ Status: ____________

____ Student Loans, Amount: ____________ Status: ____________

____ Scholarships, Amount: ____________ Status: ____________

____ Self/Parents, Amount: ____________ Status: ____________

2. Are there other family, personal, financial, or special circumstances that you would like the Selection Committee to know?

IV. Please also include:

1) **At least one and up to three recent professional or personal letters of recommendation.**

2) **An essay, attached as a separate page, of up to 500 words.** Describe your strengths, relevant experiences, and career and/or educational aspirations. Please tell us how an Ag Health Benefits scholarship will help you to achieve your goals.

3) **Your most recent school transcript(s)/ GPA.**

Application Deadline: March 31, 2025

Incomplete applications will not be considered. Please make sure you have included everything on the following checklist:

- ☐ Name, address, and contact information
- ☐ Your affiliation to Ag Health Benefits Alliance
- Information about your educational goals
- ☐ Information about the school you wish to attend and related costs
- ☐ Letter(s) of recommendation
- ☐ An essay
- ☐ School transcripts/ GPA

Return your completed application by March 31, 2025

By email: *info@aghealthbenefits.org*

By mail: AHBAEF Scholarship Committee; 5 Financial Plaza, Suite 116; Napa, CA 94558

Scholarships will be awarded based on fair, objective, and non-discriminatory methods. Finalists will be chosen based on information provided in the written application and a virtual interview with the Selection Committee. AHBAEF will notify award recipients by mail. Scholarships will be issued upon proof of educational enrollment and acceptance of program terms.

By signing this application, I am stating that all information that I have submitted is truthful and accurate.

____

Signature of Applicant **Date**

____

If under age 18, print the name of the Parent/Guardian Approving of Application Submission

____

Signature of Parent/Guardian **Date**

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