

## **Student Status Verification**

To continue health and dental coverage for a dependent child, please complete a Student Status Verification Form for each dependent child who is 19 through age 22 or who is a full time college student. Submit this completed form along with a copy of the insurance claim.

### EMPLOYEE INFORMATION

INSURED NAME:	INSURED'S SSN:
CAMPUS TELEPHONE:	E-MAIL ADDRESS:

### STUDENT INFORMATION (Student must be an eligible dependent)

NAME OF STUDENT:	STUDENT'S SSN:	STUDENT'S DATE OF BIRTH:
ADDRESS:		
CITY:	STATE:	ZIP:
Was dependent covered under your present health plan immediately prior to reaching age 19? Yes or No		
Is dependent covered under any other employer sponsored group insurance plan? Yes or No		
If yes, please provide below the name and address of the insurance plan in which the dependent is covered:		
NAME OF PLAN:		
ADDRESS:		
CITY:	STATE:	ZIP:

### SCHOOL ENROLLMENT INFORMATION

NAME OF COLLEGE OR UNIVERSITY:		
ADDRESS OF COLLEGE OR UNIVERSITY:		
CITY:	STATE:	ZIP:
COURSE OF STUDY:	STATUS: Full Time or Part Time	ACADEMIC YEAR: Semester or Quarter
TERM OF ENROLLMENT (circle one): Fall    Winter    Spring    Summer		NUMBER OF CREDIT HOURS THIS TERM:
DATES OF ENROLLMENT:		
Present Year:	From: Month _____ Year _____ to Month _____ Year _____	
Prior Year:	From: Month _____ Year _____ to Month _____ Year _____	

### CERTIFICATION

COLLEGE OR UNIVERSITY REGISTRAR CERTIFICATION:	
Registrar Signature: _____	Date: _____
I certify that the information provided by me is correct:	
Insured Signature: _____	Date: _____