

# STUDENT CERTIFICATION

## Requirements for dependent student coverage:

- Must be enrolled in an accredited institution
- Must be dependent upon subscriber for support
- Must be unmarried
- Units required are determined by the employer
- Must be younger than age 24

Dependent's name \_\_\_\_\_ Dependent's medical record number \_\_\_\_\_

Date of birth (MM/DD/YY) \_\_\_\_\_ Dependent's Social Security number \_\_\_\_\_

School name \_\_\_\_\_

School address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Student ID number \_\_\_\_\_ Number of units carried \_\_\_\_\_

Subscriber's name \_\_\_\_\_ Subscriber's medical record number \_\_\_\_\_

Group ID \_\_\_\_\_

I certify that the dependent shown meets all of the requirements for coverage on my account. I understand the Health Plan coverage for this dependent will terminate on the first day of the month following the date that any one of these requirements is no longer met.

**X**  
Subscriber's signature \_\_\_\_\_

Social Security number \_\_\_\_\_ Date \_\_\_\_\_

**Employee: Return completed form to your employer.**