

# STUDENT DEPENDENT CERTIFICATION FORM

GROUP NAME \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_

## **EMPLOYEE'S INFORMATION**

Employee Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

## **DEPENDENT INFORMATION**

Dependent's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Social Security Number \_\_\_\_\_ Gender (check one)  Male  Female

Relationship to Employee? \_\_\_\_\_

Dependent is:  
 Single  Married  Divorced  Separated

Does Dependent satisfy IRS Requirement for dependency?  
 Yes  No

## **ADDITIONAL INFORMATION This section must be completed or the form will be returned**

Name and Address of Institution where Dependent is enrolled:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is student considered a full-time student according to the requirements of the institution?  Yes  No

Number of semester hours \_\_\_\_\_  
(graduate = 9; undergraduate = 12)  
If attending trade school - no. hrs. per week \_\_\_\_\_

Please indicate which semester this form applies to:

\_\_\_\_\_ Spring \_\_\_\_\_ (year) January 1 thru August 31  
\_\_\_\_\_ Fall \_\_\_\_\_ (year) September 1 thru January 31

Is the dependent employed?  Yes  No

If yes, please provide name of employer.  
\_\_\_\_\_

Is dependent covered under any other Medical Plans?  Yes  No If, yes please provide the following:

Insured Name \_\_\_\_\_

Name and Address of Insurance Company \_\_\_\_\_

**I CERTIFY THAT THE INFORMATION IS TRUE AND COMPLETE. ALSO, I UNDERSTAND THAT ANY CHANGES TO THIS CHILD'S STUDENT STATUS MUST BE REPORTED TO MY EMPLOYER WITHIN 30 DAYS OF THE CHANGE. I AUTHORIZE THE SAID INSTITUTION TO RELEASE ANY INFORMATION REGARDING THE ENROLLMENT STATUS OF MY DEPENDENT SON/DAUGHTER.**

Patient/Authorized Person's Signature \_\_\_\_\_

Date \_\_\_\_\_

Student's Signature \_\_\_\_\_

Date \_\_\_\_\_

Registrar's Signature \_\_\_\_\_ Registrar's phone number \_\_\_\_\_

School Seal



School seal must be visible when faxed or member will need to mail in the Hard copy in order for the form to be accepted as complete.