

FULL-TIME STUDENT DEPENDENT CERTIFICATION

1. Name of Member (Employee or Retiree)	2. Member's Social Security Number
3. Name of Dependent	4. Dependent's Birthdate
5. Relationship to Member	6. Dependent's Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated
7. Dependent is under 25 years of age and meets the insurance program's definition of dependent children? <div style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</div>	
8. Is Dependent Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	8a. If Yes... <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> School Vacation Period Only <input type="checkbox"/> Other:
9. Was Dependent covered under your present employer's Insurance Plan immediately prior to the Dependent Deletion Age circled on the reverse side? <input type="checkbox"/> Yes <input type="checkbox"/> No	
10. Is Dependent covered under any other group medical insurance or pre-payment program? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, identify the other medical insurance program:	
11. Full Name and Address of School in which Dependent is Enrolled:	
12. Type of School <input type="checkbox"/> a. High School or vocational school supported or operated by state, local, or Federal government; <input type="checkbox"/> b. State university, college, or community college; <input type="checkbox"/> c. Licensed private school, college or university; <input type="checkbox"/> d. Licensed technical school, nurses' training school, beautician school, automotive school, or similar training school. <input type="checkbox"/> e. Other (please define):	
The following types of schools or courses are illustrative of those that are not acceptable for this certification: a. Part-time courses, except those where a student is completing a degree program; b. Certain specialized courses; e.g. adult education courses; c. Schools which do not provide an entire course progression; or d. Any correspondence school. e. Voluntary co-op training for which no credit hours are earned.	
13. Dates of School Term at Time of Claim: From (Month-Day-Year) To (Month-Day-Year)	
14a. Expected Dates of Course Completion From (Month-Day-Year) To (Month-Day-Year)	14b. Expected Dates of Graduation From (Month-Day-Year) To (Month-Day-Year)
I CERTIFY THAT THE ABOVE LISTED DEPENDENT QUALIFIED AS A FULL-TIME STUDENT UNDER THE PROVISIONS OF MY EMPLOYER'S MEDICAL INSURANCE PROGRAM AND THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND AUTHORIZE MY EMPLOYER TO DEDUCT THE AMOUNT OF ANY OVERPAYMENTS WHICH MAY OCCUR IN CONNECTION WITH THE PAYMENT OF CLAIMS FOR WHICH THE ABOVE IDENTIFIED DEPENDENT WAS NOT ELIGIBLE AS HE/SHE DID NOT QUALIFY AS A FULL-TIME STUDENT. I ALSO AUTHORIZE THE RELEASE OF ANY INFORMATION REQUESTED WITH RESPECT TO THIS CERTIFICATION.	
Member's Signature	Date
I CERTIFY THAT I AM A FULL-TIME STUDENT AT THE ABOVE-NAMED SCHOOL AND AUTHORIZE THE SCHOOL TO RELEASE ANY INFORMATION NECESSARY TO CONFIRM MY FULL-TIME ATTENDANCE AT THE SCHOOL FOR THE PURPOSE OF ESTABLISHING MY STUDENT STATUS.	
Dependent's Signature	Date