



## Health and Dental Plan Student Certification Form

Your family membership provides coverage for full-time students between the ages of 19 and 25. Please complete the following information so that your dependent will continue to be covered while he or she is a student.

Student's Name: \_\_\_\_\_

Student's Social Security Number: \_\_\_\_\_

Student's Date of Birth: \_\_\_\_\_

Current School Year Enrollment Date: \_\_\_\_\_

Name of School: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_

Subscriber's Employee ID: \_\_\_\_\_

Health Plan: \_\_\_\_\_

Dental Plan: \_\_\_\_\_

\_\_\_\_\_  
Subscriber's Signature

\_\_\_\_\_  
Date

Please have this form stamped by the school's Registrar's Office.

\_\_\_\_\_ is enrolled as a full-time student.

\_\_\_\_\_  
School Certification (Stamp)