

Dependent Eligibility Form

Policy Member (Please Print Name): _____

Dependent Name: _____

Policy ID #: _____

Dear Policy Member:

Our records list the above mentioned dependent as ineligible under your policy due to their age. As a result, per your policy, we need documentation showing your dependent is a Full Time Student for the following semester

_____.

Please have the following statement completed and signed by the registrar of the school the patient is now attending.

This is to certify that _____

is enrolled at _____

for the quarter/semester which began ____ / ____ / ____ and will end on ____ / ____ / ____.

This does does not (please check one) constitute Full-Time attendance at this school.

What is the expected date of graduation at this time? _____

The information above is true and accurate to the best of my knowledge.

Signature of College or University Registrar: _____ Date: _____

This information is required every semester until your child is no longer eligible under your plan.

