



Subscriber Identification Number:

Student's Name:

Student's Date of Birth (DOB):

I certify that my dependent student listed below meets all of the following requirements for eligibility as a dependent student.

- A. 19 years of age or older
B. Unmarried
C. Do you provide more than 50% support for this dependent student?
D. Is a full-time student in an accredited secondary or preparatory school or college or is eligible for a dependent student extension.*
E. Expected date of graduation

DEFINITION OF DEPENDENT STUDENT: A full-time dependent student is a person who meets all the following conditions: He/She is at least 19 years of age, unmarried, receives at least half of his/her support from the employee or member, and is enrolled full-time in an accredited secondary or preparatory school or college. If a covered dependent student is required because of illness or injury to take a medically necessary leave of absence from school, the dependent is eligible for continued health insurance coverage for the lesser of:
- One (1) year after the first day of the leave of absence or last date of attendance in school, whichever is later; or the date that coverage would otherwise terminate for the dependent student under the terms of the policy.
- The treating physician must certify to EmblemHealth that the dependent student is suffering from a serious illness or injury and that the leave of absence is medically necessary. During the continuation period, the dependent student will be entitled to the same benefits as if the dependent student was enrolled in school and not on the medically necessary leave of absence.

TO BE COMPLETED BY THE SUBSCRIBER

Employer Name
Subscriber Name
Subscriber ID #
Student Name
School Name
School Address
School City
School Phone
State
ZIP Code
The semester begins on
and ends

I confirm that the above-named dependent is registered as: Full-time student Part-time student
Student is in an accredited educational institution for the: Fall Winter Spring Summer semester
If no longer attending: graduation date: or date last attended:

*A limited extension is available for dependent students no longer enrolled full-time to provide coverage during semester breaks. Please contact your Health Benefits Administrator for more details.

I attest that the information shown above is true and complete. I understand that failure to complete this form may result in a delay, denial, or termination of coverage for the above-named dependent. I understand that EmblemHealth reserves the right to ask for more information as proof of the above-named dependent's full-time student status. I agree to advise EmblemHealth promptly of any changes in my child's dependent student status.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim concerning any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claims for each such violation.
Subscriber's Signature Date