

Full-Time Student Certification



Complete and Mail to:
Meritain Health Eligibility Dept
1 South Street
10th Floor
Baltimore, MD 21202

THE FOLLOWING INFORMATION MUST BE COMPLETED BY EMPLOYEE

Failure to submit this form will delay claims processing.

EMPLOYEE INFORMATION

Employer Group Name	Employee Name	Employee Social Security No./ID No.
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STUDENT NAME: _____

STUDENT'S SOCIAL SECURITY NO.: _____

STUDENT'S DATE OF BIRTH: _____

SCHOOL NAME: _____

SCHOOL ADDRESS: _____

SCHOOL PHONE #: _____

Is the school an accredited institution of higher learning? Yes No

Student's total number of semester credits: _____ Full-time student Part-time student

Semester date ranges: _____ **Expected graduation date:** _____

I certify that my son/daughter is unmarried, is a full-time student enrolled in an accredited school, and is financially dependent upon me for support and maintenance. I understand that coverage will terminate when he/she ceases to be financially dependent upon me for support and maintenance, marries, or ceases to be a full-time student. Full-time student coverage continues only between semester/quarters if the student is enrolled as a full-time student in the next regular semester/quarter. If the student is not enrolled as a full-time student, coverage will be terminated retroactively to the last day of the attended school term. The Employer has the right to recover contributions toward the cost of coverage made during a semester break on behalf of the Employee by the Employer if the dependent fails to return to school as a full-time student the following semester. If the son/daughter does not maintain full-time status or graduates, the son/daughter will cease to be eligible as a Dependent under the plan. Refer to the Summary of Plan Description for full-time student age limits. I understand that it is my responsibility to notify the plan administrator within 30 days from when my son/daughter no longer meets the dependent eligibility requirements. I authorize the said institution to release any information regarding the enrollment status of my son/daughter.

Failure to disclose proper information may result in denial of benefits.

I authorize the said institution to release any information regarding my enrollment.

Employee signature (Parent)

Student signature

Date signed

Date signed