



# DEPENDENT STUDENT CERTIFICATION FORM

Mail form to: GHI, P.O. Box 2821, New York, NY 10116-2821

Subscriber Identification Number: \_\_\_\_\_

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

Student's DOB: \_\_\_\_\_

Transaction Code: \_\_\_\_\_

Relationship Code: \_\_\_\_\_

Termination Date: \_\_\_\_\_

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 Yes  No
- B. Unmarried
- C. Is this dependent student your natural child, dependent stepchild or adopted child. If No, do you provide more than 50% support for this dependent student. This child must permanently reside in the member's home.
- 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, and is enrolled full-time in an accredited secondary or preparatory school or college.

### FOUR GOVERNMENT BY THE SUBSCRIBER

Employer Name																								
Subscriber Name																								
Subscriber ID #																								
Student Name																								
School Name																								
School Address																								
School City																								
School Phone																								

I confirm that the above-named dependent is registered as a:  full-time  part-time

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 refer to 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 GHI reserves the right to ask for more information as proof of the above-named dependent's full-time student status. I agree to advise GHI promptly of any changes in my child's dependent student status.

X

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

Date \_\_\_\_\_

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.