

PLEASE COMPLETE THE FOLLOWING FOR DEPENDENT STUDENTS AGE 19 OR OLDER*

(*Certain Empire Plan employer groups allow coverage until a dependent reaches age 21 before enrollment verification is needed. These include: PBA – PIA, PBA – Supervisors, PBA - Troopers)

Empire Plan Enrollee's Name: _____

Empire Plan Identification # (from NYSHIP Benefit Card): _____

Dependent Student's Name: _____

Student's Social Security #: _____

Name, address, & telephone number of school: _____	
Current Semester Enrollment: <input type="checkbox"/> full-time <input type="checkbox"/> part-time From _____ To _____	
Previous Semester Enrollment(s): From _____ To _____ <input type="checkbox"/> full-time <input type="checkbox"/> part-time From _____ To _____ <input type="checkbox"/> full-time <input type="checkbox"/> part-time From _____ To _____ <input type="checkbox"/> full-time <input type="checkbox"/> part-time From _____ To _____ <input type="checkbox"/> full-time <input type="checkbox"/> part-time From _____ To _____ <input type="checkbox"/> full-time <input type="checkbox"/> part-time From _____ To _____ <input type="checkbox"/> full-time <input type="checkbox"/> part-time	
Type of School (ie, college, trade, etc.): _____ Course of Study: _____	
Except for regular vacation periods, was student in attendance during entire period covered by this claim? <input type="checkbox"/> yes <input type="checkbox"/> no If no, explain: _____	
Anticipated date of graduation: _____ Month _____ Year _____	
Is student employed? <input type="checkbox"/> full-time <input type="checkbox"/> part-time <input type="checkbox"/> not employed	Is full-time employment only during non-school periods? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not applicable
Name, address, & telephone number of employer: _____	
Student's Marital Status: <input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> widowed <input type="checkbox"/> divorced	
Is student covered by another insurance plan? <input type="checkbox"/> yes <input type="checkbox"/> no Name, address, & ID# for other plan: _____	
If dependent has had military service, give dates: From _____ To _____	

NYS RESIDENTS – The following statement is printed pursuant to Regulation 95 of the New York State Insurance Department.

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

RESIDENTS OF STATES OTHER THAN NEW YORK – NOTICE:

Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

I have read the appropriate statement above and authorize release of any information necessary to process claims.

a. PATIENT/AUTHORIZED PERSON'S SIGNATURE: _____

DATE: _____

b. ENROLLEE/AUTHORIZED PERSON'S SIGNATURE: _____

DATE: _____

SUBMIT TO:

EMPIRE PLAN • UNITED HEALTHCARE INSURANCE COMPANY OF NEW YORK • PO BOX 1600 • KINGSTON, NY 12402-1600