



Chairperson Barbara Alderson Trustees Howard Brotman, Debi Ives, Donald Tartre, Ray Uzeta and Mitch Woodbury

### IMPORTANT NOTICE STUDENT STATUS VERIFICATION

Employee Name \_\_\_\_\_ Employer \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

RE: \_\_\_\_\_  
Dependent Name \_\_\_\_\_ Employee's Social Security Number \_\_\_\_\_

Our records show that you have a dependent, named above, who is, or will soon be, between the ages of 19 and 25. To determine this dependent's continuing eligibility, you will need to complete and sign this letter.

- The dependent listed above **is not** a full-time student. (This dependent will lose eligibility for coverage, which may reduce the cost of coverage; this dependent may also have benefit continuation rights – please refer to your Summary Plan Description).
- The dependent listed above **is** currently a full-time student (or on summer/school holiday), at a school that meets the requirements, outlined in your Summary Plan Description. In addition, this dependent must be unmarried and you must be claiming this dependent on your taxes.
- The dependent listed above, regardless of age, is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition and is chiefly dependent upon me for support and maintenance. If this box is checked, you will be provided with a certification to complete and return.

Please complete the following:

Name of School: \_\_\_\_\_

Address of School: \_\_\_\_\_

School's Telephone Number: \_\_\_\_\_

Dependent's Social Security number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

This verification pertains to the following semester/quarter:  Fall 20\_\_\_\_  Winter 20\_\_\_\_  Spring 20\_\_\_\_

If your dependent resides out-of-state, please provide their out-of-state address.

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Your signature below will allow the Plan to verify your dependent's enrollment, if necessary, and allow the Plan to seek reimbursement for claims paid, from you, if your dependent does not qualify as a full-time student. If we do not receive this Full-Time Student verification letter within 30 days prior to the commencement of the semester or quarter (September 1<sup>st</sup> and/or February 1<sup>st</sup>), you will receive a mandated COBRA election notice.

By signing this form, I assert that the information furnished is true and correct. I understand that failure to return the form to the address/fax below before the commencement of the semester/quarter may result in the termination of coverage for the dependent named above.

Signature \_\_\_\_\_ Date \_\_\_\_\_