

**The Employee Benefit Service Center  
THIRD PARTY ADMINISTRATOR**

Please return form to  
Attn: Eligibility Department  
The Employee Benefit Service Center  
P.O. Box 1803  
Dublin, Ohio 43017  
Ph.: 800-820-4516; Fax: 614-793-9733

**STUDENT CERTIFICATION**

To the Plan Participant:

Your benefit plan must have verification of full-time student status in order to provide coverage for dependent students of participating employees. To improve and expedite service, both you and your dependent student must sign the completed form. In addition, it is necessary for the student to get a signed confirmation from the school in the section provided below. Once this form has been completed, please forward it to the Eligibility Department at the above address or to the listed fax number.

1. Employee's Employer: \_\_\_\_\_ Group Number: \_\_\_\_\_  
2. Employee's Name: \_\_\_\_\_ Member ID: \_\_\_\_\_  
3. Student's Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Address: \_\_\_\_\_  
Number and Street City State Zip  
4. Student's Birthday: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ 5. Relationship to Employee: \_\_\_\_\_  
6. Student is:  Single  Married  Divorced  Separated  
7. Is student employed?  Yes  No If Yes,  Full-time  Part-time  School Vacation Period Only  
Name and address of employer: \_\_\_\_\_  
8. Is student covered under any other group medical insurance or pre-payment program?  Yes  No  
If yes, identify the other insurance carrier: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
Policyholder: \_\_\_\_\_  
9. Full name and address of school in which student is enrolled: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I AUTHORIZE THE ABOVE NAMED SCHOOL TO VERIFY AND/OR RELEASE ANY INFORMATION NECESSARY TO CONFIRM MY FULL-TIME ATTENDANCE AT THE SCHOOL FOR THE PURPOSE OF ESTABLISHING MY STUDENT STATUS.

\_\_\_\_\_  
Signature of Student Date

I CERTIFY THAT THE DEPENDENT IS A FULL-TIME STUDENT AND THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND AUTHORIZE RELEASE OF ANY INFORMATION REQUESTED WITH RESPECT TO THIS CERTIFICATION.

\_\_\_\_\_  
Signature of Policyholder / Date

**- SCHOOL CONFIRMATION -**

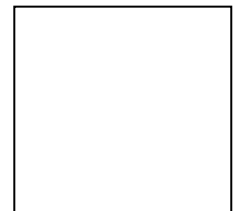
SCHOOLSTAMP

Please confirm whether the above-named student is enrolled at your institution by checking the appropriate item(s) below:

The individual identified above:  is a full-time student  is a part-time student

Please indicate the dates of the current enrollment period:

From: \_\_\_\_\_ To: \_\_\_\_\_



\_\_\_\_\_  
Signature of Registrar or Other School Official

\_\_\_\_\_  
Date