Health Advantage

An Independent Licensee of the Blue Cross and Blue Shield Association

P.O. Box 8069
Little Rock, Arkansas 72203-8069

*****PLEASE RETURN COMPLETED FORM TO YOUR BENEFITS ADMINISTRATOR*****

STUDENT VERIFICATION LETTER

Subscriber Name_____

Subscriber ID #_____Subscriber SSN_____

Address_____

Group Name_____Group Number_____

To continue coverage, eligible dependents over the maximum dependent age according to the group's contract must be enrolled as a full-time student at an accredited educational institution, and be financially dependent on the Subscriber for support. Health Advantage verifies eligibility annually.

This form may be used to update student status at anytime. Failure to provide complete and accurate information may result in cancellation of coverage.

The completed letter may be sent to: Membership Accounting, Health Advantage, P. O. Box 8069, Little Rock, Arkansas 72203-8069, or faxed to: 501-301-6869 (Customer Accounts).

If a student is no longer eligible for coverage as a dependent, he/she may be eligible for continuation of coverage under federal and state guidelines.

If you have questions, contact Customer Service at 1-800-843-1329.

STUDENT VERIFICATION INFORMATION

☐ Member is not a full-time student. Date member was no longer student_____
(Member's coverage will be terminated according to the terms of the group contract)

☐ Member is full-time student at an accredited institution:

Member Name (Student) Date of Birth Date Current Semester began

Name of Educational Institution

City State Zip Code (Educational Institution)

Number of Hours Enrolled Graduation date if known Phone Number of Educational Institution

Subscriber Signature **Date**

5/2004

FAX 501-301-6869