Student Certification Form

Please provide the following information concerning the dependent child who is eligible to continue coverage as a "student dependent." To continue coverage beyond age 19, this form must be returned along with documentation from the accredited institution that reflects the name of the student, name of school, semester attending and number of hours attending. **Failure to return the necessary documents will result in loss of coverage.**

GENERAL INFORMATION

Group No._____ Member ID No._____

Member Name _____

Student Dependent's Name _____

Student Dependent's Date of Birth _____ / _____ / _____ MM/DD/YY

Relationship to Employee _____

Is Student Dependent: Single _____Married _____Divorced _____Separated _____

Is Student principally dependent on you for financial support? Yes___ No ____

SCHOOL INFORMATION

Is student dependent considered a full-time student according to requirements of the institution attended?
____Yes ____No
Number of credit hours dependent is taking this term_____
Name of the school in which the student dependent is enrolled _____
Address & Phone # of school _____
_____
Type of school (Example: high school, college, trade, etc.) _____
On what date did the student dependent become a full-time student? ___/___/___MM/DD/YY
What are the dates of the school semester? Current ___/___/___ to ___/___/___ MM/DD/YY
Prior ___/___/___ to ___/___/___ MM/DD/YY
Upcoming___/___/___ to ___/___/___ MM/DD/YY
If graduation is expected within the next 12 months please provide an anticipated date of graduation
___/___/___MM/DD/YY

☐ **Required School Documentation Enclosed**

An update of this form must be completed periodically until the dependent attains the maximum age as defined in your health benefit plan booklet or until graduation, whichever comes first.

I hereby certify that the above information is correct. I also understand that if the above-named dependent child ceases to be eligible as a student, that child will no longer be eligible for health coverage unless other eligibility provisions apply. I must notify my employer who will notify Blue Cross and Blue Shield of Illinois to cancel coverage on the dependent child. In addition, I understand that if Blue Cross and Blue Shield of Illinois needs to contact the educational institution to obtain enrollment status and dates of school terms, my dependent child will be asked to authorize release of student records.

Signature of Member: _____ Date: _____