HIGHMARK

Dependent Name: _____

Subscriber ID#: _____

Group #: _____

STUDENT DEPENDENT VERIFICATION

To continue medical coverage, we must verify that your dependent age 19 or over is a fulltime student at an accredited College or University. Failure to do so will result in rejection of claims for this dependent.

Please check the applicable item below and return this form to the address listed above.

If you have any question regarding the completion of this form or if your dependent is no longer a fulltime student and wish to discuss your options for continued coverage, please feel free to contact us at the phone number listed on the back of your identification card.

☐ **Presently a fulltime student registered for no less than 12 credit hours for the Period (semester) of _____**

Accredited College or University Information

_____

College or University

_____

Address

_____

City

_____ _____

Student ID Number **Expected Date of Graduation**

☐ **No Longer a fulltime student as of _____**

I certify that the above named dependent is currently enrolled as a fulltime student at the College or University identified above. I pledge to notify Highmark of NENY when my dependent's fulltime status ends.

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

Contract Holder signature: _____ Date: _____

FAILURE TO RESPOND WILL RESULT IN TERMINATION OF THIS DEPENDENT'S COVERAGE