Dependent Eligibility Certification Form

General Information	
Member Name:	Group Plan #
Dependent Name:	Dependent Date of Birth:
Member Address:	
Member SS#:	

Student Certification

1. Name of school in which dependent is enrolled:_____
2. Address of school:_____
3. Telephone # of school:_____
4. Expected date of graduation (if this year): _____/_____
   MO YR
5. Student ID# _____

Disability Certification

1. Is dependent now incapable of self-support because of a disability? _____Yes _____No
2. Age of dependent when disability occurred: _____
3. Nature of disability (Please provide as much detail as possible):

_____

_____

4. Prognosis (estimate months or years):_____
5. Name and address of Primary Care Physician: _____
   _____
   _____

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND AUTHORIZE RELEASE OF ANY INFORMATION REQUEST IN REGARD TO THE CERTIFICATION.

_____ _____

Member Signature Date Signed

Any person who includes any false or misleading information on an application for insurance commits a fraudulent insurance act and is subject to criminal and civil penalties.

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