BlueCross BlueShield of Western New York
A Division of HealthNow New York Inc.
An Independent Licensee of the BlueCross BlueShield Association
PO Box 80, Buffalo, NY 14240-0080

Dependent Name: _____

Subscriber ID#: _____

Group #: _____

STUDENT DEPENDENT VERIFICATION

To continue medical coverage, we must verify that your dependent age 19 or over is a full-time 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 full-time 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 full-time 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 full-time student as of _____**

I certify that the above named dependent is currently enrolled as a full-time student at the College or University identified above. I pledge to notify BlueCross BlueShield of WNY when my dependent's full-time status ends.

Contract Holder signature: _____

Date: _____

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

Any person who submits false and/or misleading information with the intent to defraud an insurance company, may be subject to civil and Criminal Sanctions and may have their insurance coverage terminated.