



Proof of Student Status for Dependents

To Be Completed by College or High School

_____ is enrolled as a
Name of Dependent Student, _____ *Social Security #*

full-time student at _____
Name of College or High School

for the _____ school semester.

Anticipated Date of Graduation _____.

Signature of School Official

Title of School Official

Date

Official School Seal

To Be Completed by Parent

Signature of Subscribing Parent _____

Subscribing Parent's Employer _____

Student's Vytra ID No. _____

Student's Effective Date of Enrollment _____

Return this form to the Customer Service Department at:

Vytra Health Plans
395 North Service Road
Melville, NY 11747-3127

631-694-6565 • Fax 631-249-6697