



STUDENT COVERAGE QUESTIONNAIRE

Member's Identification #: _____

Dependent's Name: _____

1. Dependent's Date of Birth: _____

2. Relationship to employee: _____

3. Is dependent: Single _____ Married _____ Divorced _____ Separated _____

4. Is dependent employed? Yes _____ Full-time _____ Part-time _____ No _____

5. List any other group insurance or pre-payment program the dependent is covered under

6. Is the dependent a student? Yes _____ No _____

If yes: Full-time _____ Part-time _____

7. School name & address _____

8. Type of school (college, trade, etc.) _____

9. Expected date of: Graduation _____

Course Completion: _____

10. Was the dependent a full-time student at an accredited school who is now on a leave of absence from the school due to illness or injury? Yes _____ No _____

If yes, what is the name of the school attended prior to the Medical leave?

What is the date the medical leave began? _____

(YOU MUST ALSO ATTACH A LETTER FROM THE STUDENT'S DOCTOR WHICH DOCUMENTS HIS/HER ILLNESS OR INJURY AND CERTIFIES TO THE MEDICAL NECESSITY OF THE LEAVE OF ABSENCE FROM THE SCHOOL)

I hereby certify that the above is correct to the best of my knowledge

Signature of employee _____ Date _____

NOTE: After completing the above information, forward this form to the school for their certification of question of questions 6 through 10.

SCHOOL CERTIFICATION

Signature of Registrar of School Official and Imprint _____ Date _____
of School Seal

I understand that 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.