



FULL-TIME STUDENT VERIFICATION FORM

PO BOX 94928, CLEVELAND OH 44101-4928
FAX: 440-356-0140

Date:

Employer:

Dependent:

Dear Enrollee:

Our records indicate that your above named dependent child has reached the limiting age under your employer's group benefit plans and may no longer be eligible for coverage, unless the dependent is:

a full time student during the **current semester / quarter** carrying at least 12 credit hours at an accredited school; **OR**

mentally and/or physically incapable of providing self support.
(Check here _____ if this applies and return this form)

If the above applies, please complete the appropriate sections on the reverse side of this form and return it to us. If the above does not apply, the child's group coverage will automatically end. However, your dependent may qualify for continuation coverage under Federal Law. Please contact your benefits representative for information regarding continuation coverage if your child is not eligible under the above listed provision of the group health plan.

Please respond at your earliest convenience -- but, in any case, within 45 days of the date of this letter. If we do not hear from you within this period, coverage on the above named dependent will automatically end as of the date the limiting age was reached.

Thank you.

Mail your reply to: Meritain Health
P O Box 94928
Cleveland, Ohio 44101-4928
ATTN: Membership Services

Or Fax your reply to: (440) 356-0140

Call Customer Service at the number listed on your identification card with any questions.

MERITAIN HEALTH

Your employer's health plan provides benefits for your eligible dependent children. Certain over age dependent children must meet specific conditions in order to continue their coverage. This form, when completed, will assist us in determining if your over age dependent child can continue his/her coverages.

TO BE COMPLETED BY THE ENROLLEE

Please provide the information requested below. Be sure your response is complete so that your dependent's claim will not be unnecessarily delayed.

- 1. What percentage of the dependent's support is provided by the enrollee? _____
- 2. Is dependent employed on a full time basis? Yes _____ No _____? (If yes, provide employer's complete name, address and telephone number.)

- 3. Is dependent covered under any other employer group insurance, prepayment plan or union group insurance?
Yes _____ No _____ (If yes, provide policy number, name, address & telephone number of other claims payer.)

- 4. Will you, for this calendar year, claim this dependent on your Federal Income Tax return as an eligible dependent?
Yes _____ No _____.

I hereby certify any insurance company, organization, employer, or educational facility to release any information requested with respect to this statement to Meritain Health. Further, I authorize all such entities to provide confirmation of this information as well as providing subsequent verification of continued educational status for a period of not less than eighteen (18) months.

I certify that the information furnished by me in support of this claim is true and correct to the best of my knowledge.

Enrollee's Signature	Date	Dependent's Signature	Date
		(Required if over age 17)	

Enrollee's Social Security Number

TO BE COMPLETED BY SCHOOL REGISTRAR

Student name: _____ Student's status is _____ Full time or _____ Part time

Number of credit hours: _____ Semester: _____ Quarter: _____

Present school term from: _____, 20 _____ to: _____, 20 _____

School Name: _____

Address: _____

Phone number: (_____) _____

Signature of Registrar: _____ Date: _____

Return to: Meritain Health, Membership Services, P O Box 94928, Cleveland, Ohio 44101-4928
For Customer Service, call the number listed on your identification card. Fax: (440) 356-0140