

# DEPENDENT STUDENT CERTIFICATION FORM



Mail form to: GHI, P.O. Box 2821, New York, NY 10116-2821

**TO BE COMPLETED BY THE SUBSCRIBER**

Employer Name																																	
Subscriber Name																																	
Subscriber ID #																																	
Student Name																																	
School Name																																	
School Address																																	
School City													State			Zip Code																	
School Phone							-							-							The semester begins on			and ends									

**DEFINITION OF DEPENDENT STUDENT:** A full-time dependent student is a person who meets all the following conditions: He/She is at least 19 years of age, unmarried, and is enrolled full-time in an accredited secondary or preparatory school or college.

If a covered dependent student is required because of illness or injury to take a medically necessary leave of absence from school, the dependent is eligible for continued health insurance coverage for the lesser of:

1. One (1) year after the first day of the leave of absence or last date of attendance in school, whichever is later; or
2. the date that coverage would otherwise terminate for the dependent student under the terms of the policy.

The treating physician must certify to GHI that the dependent student is suffering from a serious illness or injury and that the leave of absence is medically necessary. During the continuation period, the dependent student will be entitled to the same benefits as if the dependent student was enrolled in school and not on the medically necessary leave of absence.

I certify that my dependent student listed below meets all of the following requirements for eligibility as a dependent student.

	Yes	No
A. 19 years of age or older	<input type="checkbox"/>	<input type="checkbox"/>
B. Unmarried	<input type="checkbox"/>	<input type="checkbox"/>
C. Is this dependent student your natural child, dependent stepchild or adopted child. If No, do you provide more than 50% support for this dependent student. This child must permanently reside in the member's home.	<input type="checkbox"/>	<input type="checkbox"/>
D. Is a full-time student in an accredited secondary or preparatory school or college or is eligible for a dependent student extension.*	<input type="checkbox"/>	<input type="checkbox"/>
E. Expected date of graduation ____/____/____.		

I confirm that the above-named dependent is registered as a:     full-time     part-time

Student is in an accredited educational institution for the:     Fall     Winter     Spring     Summer semester.

If no longer attending: Graduation date: \_\_\_\_\_ or Date last attended: \_\_\_\_\_

\*A limited extension is available for dependent students no longer enrolled full time to provide coverage during semester breaks. Please refer to your Health Benefits Administrator for more details.

I attest that the information shown above is true and complete. I understand that failure to complete this form may result in a delay, denial or termination of coverage for the above-named dependent. I understand that GHI reserves the right to ask for more information as proof of the above-named dependent's full-time student status. I agree to advise GHI promptly of any changes in my child's dependent student status.

**X** \_\_\_\_\_ Date \_\_\_\_\_

Subscriber's Signature

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim concerning 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 claims for each such violation.