BlueCross BlueShield of Illinois

P.O. Box 805107
Chicago, IL 60680-4112

Student Certification

Please provide the following information concerning the dependent child who is eligible to continue coverage as a "student dependent." To continue coverage beyond the maximum age limit specified in your contract for dependents, this form must be received within 90 days of the affected dependent becoming eligible for coverage as a "student dependent."

GENERAL INFORMATION

Group No._____ Member ID No._____

Member Name _____

Student Dependent's Name _____

Student Dependent's Date of Birth _____ / _____ / _____ MM/DD/YY

Relationship to Employee _____
Is Student Dependent: Single _____Married _____Divorced _____Separated _____
Is Student Dependent Employed Yes___ No ____
If Yes: Full Time _____ Part Time _____ School Vacation Period Only _____

SCHOOL INFORMATION

Is student dependent considered a full-time student according to requirements of the institution attended?
____Yes ____No
Number of credit hours dependent is taking this term_____
Name of the school in which the student dependent is enrolled _____
Address & Phone # of school _____
_____
Type of school (Example: high school, college, trade, etc.) _____
On what date did the student dependent become a full-time student? ___/___/___MM/DD/YY
What are the dates of the school semester? Current ___/___/___ to ___/___/___ MM/DD/YY
Prior ___/___/___ to ___/___/___ MM/DD/YY
If graduation is expected within the next 12 months please provide an anticipated date of graduation
___/___/___MM/DD/YY

ADDITIONAL INFORMATION

Please complete *(the following information is only applicable for certain groups for student certification).*
Does student dependent satisfy Internal Revenue Service requirements for dependency (i.e., more than 50% financial support is provided, the dependent attends school full time for a minimum of five (5) months in a calendar year, etc.)?
_____Yes _____No
Is Student Dependent an unpaid Missionary? Yes _____ No _____ If Yes, Provide information regarding sponsorship and dates of service:_____

I hereby certify that the above information is correct. I also understand that if the above-named dependent child ceases to be eligible as a student, that child will no longer be eligible for health coverage unless other eligibility provisions apply. I must notify my employer who will notify Blue Cross and Blue Shield of Illinois to cancel coverage on the dependent child. In addition, I understand that if Blue Cross and Blue Shield of Illinois needs to contact the educational institution to obtain enrollment status and dates of school terms, my dependent child will be asked to authorize release of student records.

Signature of Member: _____ Date: _____