EmblemHealth

STUDENT VERIFICATION PARENT AFFIDAVIT FORM

Mail form to: Membership, PO 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 _____

_____ City _____ State _____ ZIP Code

School Phone _____

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, receives at least half of his/her support from the employee or member, 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 EmblemHealth 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	☐	☐
B. Unmarried	☐	☐
C. Receives at least half of his/her support from the employee or retired employee.	☐	☐
D. Is a full-time student in an accredited secondary or preparatory school or college.	☐	☐

E. Expected date of graduation _____.

I confirm that the above-named dependent is registered as a: ☐ full-time ☐ part-time
student at an accredited educational institution for the: ☐ Fall ☐ Winter ☐ Spring ☐ Summer semester

The semester begins on _____ (Month) _____ (Year) and ends _____ (Month) _____ (Year).

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 EmblemHealth reserves the right to ask for more information as proof of the above-named dependent's full-time student status. I agree to advise EmblemHealth promptly of any changes in my child's dependent student status.

X _____ _____

Subscriber's Signature Date

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.