

**IMPORTANT – STUDENT VERIFICATION INFORMATION FOR CONTINUATION OF COVERAGE**

**Insured Information**

Member ID: \_\_\_\_\_

Employee: \_\_\_\_\_

Student ID: \_\_\_\_\_

Student Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Employer/Plan Administrator**

Employer Name: \_\_\_\_\_

Group # \_\_\_\_\_



**THIRD PARTY ADMINISTRATOR**

SIGNIFICA BENEFIT SERVICES, INC.

P.O. BOX 7777

LANCASTER, PA 17604-7777

TELEPHONE: 717-581-1300 800-433-3746 FAX: 717-581-1319

**This section must be completed by the student and employee.**

I understand that because I am age 19 or older, I must be enrolled as a student in regular full-time attendance at a high school, accredited college or university in order to be eligible for coverage under the health plan. With my signature below, I authorize the school to release this information to Significa Benefit Services, Inc. as requested. **It is also my obligation to notify Significa Benefit Services of any change in my student status.**

If not attending school check here  and sign below. Terminate from coverage as of \_\_\_\_/\_\_\_\_/\_\_\_\_.

I authorize \_\_\_\_\_  
Name of School City & State of School

to provide full-time student status information to Significa Benefit Services, Inc.

\_\_\_\_\_ Date Student Signature Employee Signature

**Employee: You must forward this form to the school for completion.**

School Name: \_\_\_\_\_

Address and Phone No: \_\_\_\_\_

Is your school accredited?  Yes  No  
Provide name of accrediting body or organization: \_\_\_\_\_

WEB Address: \_\_\_\_\_

Can this information be verified through the Internet? \_\_\_\_\_

Verified by: \_\_\_\_\_

Date: \_\_\_\_\_

1. Is the above student currently enrolled?  
 Yes  No
2. Number of units carried: \_\_\_\_\_ for the semester beginning on \_\_\_\_\_ and ending on \_\_\_\_\_.
3. Number of units to be considered a full-time student \_\_\_\_\_.
4. Expected graduation date: \_\_\_\_\_.

**And/or supporting documentation on school letterhead may be attached.**

**Note:** This form does not confirm eligibility under the plan/policy. Student status verification is required for each semester. **Failure to respond within 30 days will result in coverage termination for this dependent.**