

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:

- Is the above student currently enrolled?
Yes No
- Number of units carried: _____ for the semester beginning on _____ and ending on _____.
- Number of units to be considered a full-time student _____.
- 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.**