



BlueCross BlueShield of New Mexico

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 should be received within 60 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 New Mexico to cancel coverage on the dependent child. In addition, I understand that if Blue Cross and Blue Shield of New Mexico 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: _____