

# Hope College and Blue Cross Blue Shield of Michigan

## Dependent Eligibility Verification Form for Benefit Year 2010-11

*(The Health Care Reform provision allowing dependents coverage thru age 26 is effective on the next renewal for employer sponsored health plans ~ for Hope College this will be July 1, 2011 ~ therefore, for this benefit year this requirement/verification is still necessary.)*

**Subscriber/Employee's Name:**

**Dependent's Name:**

**Birth Date:**

Please check one box below that applies to your dependent:

- Yes**, my dependent listed above is eligible to continue coverage as he/she is enrolled as a full-time student at the accredited educational institution listed below. A full-time student is defined as 12 credit hours or the designated hours established by the educational institution. (Please provide information for the most recent semester/quarter in 2010.)

School Name:

School Address:

Registrar/Business Office Phone Number:

Number of credits/hours:

Semester/Quarter:

- No**, my dependent is not a full time student at an accredited educational institution. Please provide the date that your dependent was no longer considered a full-time student: \_\_\_\_/\_\_\_\_/\_\_\_\_ (MM/DD/YY).  
*(Note: dependents who turn(ed) 19 during 2010 will maintain coverage until 12/31/2010. All other dependents coverage will be cancelled effective of the date they were no longer considered a full-time student.)*
- Disabled Eligibility:** Please contact us at 616.395.7818 or [vanderzwaag@hope.edu](mailto:vanderzwaag@hope.edu) if your dependent is not capable of self-sustaining employment or meeting the requirements of full-time student as described above because of a mental or physical handicap or disability that is incapacitating. We will require additional information from you to determine whether or not your dependent is eligible for coverage.
- Leave of Absence from School due to Illness or Injury:** Please contact us at 616.395.7818 or [vanderzwaag@hope.edu](mailto:vanderzwaag@hope.edu) if your dependent has taken a leave of absence from school due to an illness or injury. We will require additional information from you to determine whether or not your dependent is eligible for coverage.

*The above information is correct to the best of my knowledge. I understand that misrepresentation of any information may result in termination of my policy. If my dependent becomes ineligible at any time, I am responsible for notifying my employer immediately.*

**Subscriber's Signature:**

**Date:**

**Subscriber's Phone Number:**