

Hope College and Blue Cross Blue Shield of Michigan

Dependent Eligibility Verification Form

Academic Year 2009-10

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 2009.)

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 2009 will maintain coverage until 12/31/2009. 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 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 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: