BlueCross BlueShield of Illinois

Student Certification Form

Please provide the following information concerning the unmarried dependent child who is eligible to continue coverage as a "student dependent." To continue the Dependent's coverage beyond the maximum age limit specified in your health benefit plan booklet for dependents, this form must be received as quickly as possible (refer to your health benefit plan booklet for the exact number of days).

General Information

Group No. _____ Member Identification 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 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? (*MM/DD/YY*)

Current _____ to _____

Prior _____ to _____

Upcoming _____ to _____

If graduation is expected within next 12 months, please provide anticipated graduation date. (*MM/DD/YY*) _____

Additional Information: The following information is only applicable for certain groups for student certification.

Does student dependent satisfy Internal Revenue Service requirements for dependency?
For example: 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 dates of service (*MM/DD/YY*) and sponsorship: _____

_____

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 Illinois to cancel coverage on the dependent child. In addition, I understand that if Blue Cross and Blue Shield of Illinois 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.

Member Signature _____ Date (*MM/DD/YY*) _____

All fields on this form MUST be completed.

RETURN COMPLETED FORMS TO: Blue Cross and Blue Shield of Illinois
P.O. BOX 805107
Chicago, IL 60680-4112