



STUDENT VERIFICATION FORM

EMPLOYEE NAME (LAST, FIRST MI):			ALTERNATE ID # OR SS #: <i>(ID # can be found on your ID card)</i>	
LAST	FIRST	MI		
DEPENDENT NAME (LAST, FIRST MI):			SOCIAL SECURITY NUMBER:	
LAST	FIRST	MI		
IS THIS DEPENDENT A STUDENT?:				
<input type="checkbox"/> NO – My dependent is no longer a student. His / Her Student status ended on _____ MM/DD/YYYY				
<input type="checkbox"/> YES – Please complete the following questions:				
NAME OF SCHOOL:			REGISTRAR'S PHONE NUMBER:	
ADDRESS OF SCHOOL:				
STREET ADDRESS	CITY	ST	ZIP	COUNTY
FALL SCHOOL SEMESTER (MONTH/YEAR): FROM _____ - To _____				
DEPENDENT STUDENT IS: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time			NUMBER OF CREDIT HOURS:	
IS DEPENDENT INTENDING TO ENROLL FOR THE NEXT SPRING SEMESTER? <input type="checkbox"/> YES <input type="checkbox"/> NO				
SPRING SCHOOL SEMESTER (MONTH/YEAR): FROM _____ - To _____				
DEPENDENT STUDENT IS: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time			NUMBER OF CREDIT HOURS:	
EXPECTED GRADUATION DATE: _____				
WAS DEPENDENT ATTENDING SCHOOL DURING THE LAST SEMESTER? <input type="checkbox"/> Yes <input type="checkbox"/> No				
DATE OF LAST SEMESTER ENROLLED: FROM _____ - To _____				

I certify that the above information is true, and understand that I may be held responsible for any overpayment made, on behalf of my dependent, due to misrepresented student information. I understand if my dependent ceases to be a full-time student, it is my or my dependent's responsibility to notify the Plan Administrator within sixty (60) days of the loss of student status to be eligible for COBRA.

EMPLOYEE SIGNATURE

DATE

Please return this form to the Lifetime Benefit Solutions address displayed on the back of your benefit ID card.

Doing business as LBS Administrators and Flexible Benefit Insurance Solutions in California. Doing business as LBS Administrators in New Hampshire.