



## STUDENT VERIFICATION FORM

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