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STUDENT VERIFICATION PARENT AFFIDAVIT FORM

Mail form to: P.O. Box 2794, New York, NY 10117-3255

TO BE COMPLETED BY THE SUBSCRIBER

Employer ID: _____ Employer Group Type: _____

Subscriber ID: _____ Subscriber Name: _____

Student ID: _____ Student Name: _____

Student DOB: _____

DEFINITION OF DEPENDENT STUDENT: A full-time dependent student is a person who meets all the following conditions: He/She is at least 19 years of age, unmarried, receives at least half of his/her support from the employee or member, and is enrolled full-time in an accredited secondary or preparatory school or college.

If a covered dependent student is required because of illness or injury to take a medically necessary leave of absence from school, the dependent is eligible for continued health insurance coverage for the lesser of:

1. One (1) year after the first day of the leave of absence or last date of attendance in school, whichever is later; or 2. the date that coverage would otherwise terminate for the dependent student under the terms of the policy.

The treating physician must certify to HIP that the dependent student is suffering from a serious illness or injury and that the leave of absence is medically necessary. During the continuation period, the dependent student will be entitled to the same benefits as if the dependent student was enrolled in school and not on the medically necessary leave of absence.

You must **answer in full** and check the applicable boxes regarding the eligibility of the dependent listed above.

He or she:

A. Is 19 years of age or older. ❒ Yes ❒ No

B. Is not married. ❒ Yes ❒ No

C. Receives at least half of his or her support from the subscriber or retired subscriber. ❒ Yes ❒ No

D. Is enrolled in an accredited secondary or preparatory school or college. ❒ Yes ❒ No

E. Is on leave of absence from school because of illness or injury. ❒ Yes ❒ No

F. Is handicapped. ❒ Yes ❒ No

I confirm that the above-named dependent is registered as a: ❒ full-time ❒ part-time

student at an accredited educational institution for ❒ Fall 2010 ❒ Spring 2011

School Name _____

School Address _____

_____ _____ _____

City State Zip Code

School Phone _____ Expected date of graduation _____

I attest that the information shown above is true and complete. I understand that failure to complete this form may result in a delay, denial or termination of coverage for the above-named dependent. I understand that HIP reserves the right to ask for more information as proof of the above-named dependent's full-time student status. I agree to promptly advise HIP of any changes to my child's dependent student status.

X _____ _____

Subscriber's Signature Date

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim concerning any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claims for each such violation.