

**Questionnaire for Verifications
Of Dependent Eligibility**



DATE	SUBSCRIBER'S NAME (EMPOYER)	DEPENDENT NAME
NAME OF HEALTHPALN:	HEALTHPLAN CODE:	ID NUMBER
GROUP NAME	GROUP/DIVISION NUMBER	

SECTION A

STUDENT VERIFICATION (Check the Appropriate Box)
 Named dependent qualifies for coverage under the definition of full-time student. He/She is enrolled for 12 or more credit hours at the following institution:

Name of Institution	Address
(a) A signed letter from the Registrar or Dean of Students, substantiating full-time student status (b) A copy of the current semester's tuition bill, disclosing total credit hours or, (c) A copy of the schedule confirming full-time student status	
<input type="checkbox"/> Named dependent does not qualify as full-time student.	
<input type="checkbox"/> Named dependent is married.	Date of marriage:

SECTION B

HANDICAPPED DEPENDENT VERIFICATION
 Named dependent qualifies for coverage under the Handicapped Dependent extension of coverage.
Please include the most recent medical records that document the disabling condition. Included in this documentation should be a statement from the treating physician describing the current disability/handicapped condition, modes of treatment and prognosis.

Nature of Child's Disability:

Has the Child ever received Social Security Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, is the Child Eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare Claim Number
Effective Date of Medicare PART A	Is the Child currently under the care of a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No PART B	
Name and Address of Doctor:		
<input type="checkbox"/> Named dependent does not qualify as a handicapped dependent.		

I certify that all the above information is true and correct to the best of my knowledge. A Photostat of this authorization shall be as valid as the original. I hereby authorize any insurance company, administrator, prepaying organization, employer, pharmacy, hospital, physician, or organization to release all information with respect to myself or my dependents which may have a bearing on the eligibility of coverage.

Signature of Subscriber (Employee)

Date Signed

Dependent eligibility verification will be required periodically.