



**Arkansas
BlueCross BlueShield**
An Independent Licensee of the Blue Cross and Blue Shield Association

Arkansas Blue Cross and Blue Shield
ATTN: MemBRS Model Office 8-UCC
P O Box 2181
Little Rock, AR 72203-9974
Fax 501-399-3828
E-mail: ABCBSStudentVerification@arkbluecross.com

Health Advantage



An Independent Licensee of the Blue Cross and Blue Shield Association
Health Advantage
ATTN: Customer Accounts
P O Box 8069
Little Rock, AR 72203-8069
Fax 501-301-6869
E-Mail: HAcustacct@arkbluecross.com

STUDENT VERIFICATION FORM

Member Name _____

Member Address _____

Member ID# _____ Member SSN# _____

Group Name _____ **Group Number** _____

To continue coverage, eligible dependents over the maximum dependent age according to the group's contract must be unmarried, enrolled as a full-time student at an accredited educational institution; and be financially dependent on the Member for support. Arkansas Blue Cross and Blue Shield and Health Advantage verify eligibility annually.

This form may be used to update student status at any time. Failure to provide complete and accurate information may result in cancellation of coverage.

The completed form may be mailed, faxed, or e-mailed. Please refer to the applicable information above.

If a student is no longer eligible for coverage as a Dependent, he/she may be eligible for continuation of coverage under federal and state guidelines.

If you have questions, please contact Customer Service.

STUDENT VERIFICATION INFORMATION

Dependent Name _____ Date of Birth _____ / _____ / _____

Change coverage as indicated below:

Dependent **is** a full-time student at an accredited institution. Date Current Semester began: _____ / _____ / _____
(Dependent's coverage will be terminated according to the terms of the group contract)

Dependent **is not** a full-time student or **is** married Date of Occurrence: _____ / _____ / _____
(Dependent's coverage will be terminated according to the terms of the group contract)

Name of Educational Institution _____

City _____ State _____ Zip Code (Educational Institution) _____

Educational Institution Phone # _____ Hours Enrolled _____ Graduation date (if known) _____ / _____ / _____

Member Signature _____
Date