

Health Advantage



An Independent Licensee of the Blue Cross and Blue Shield Association

P.O. Box 8069

Little Rock, Arkansas 72203-8069

*****PLEASE RETURN COMPLETED FORM TO
YOUR BENEFITS ADMINISTRATOR*****

STUDENT VERIFICATION LETTER

Subscriber Name _____

Subscriber ID # _____ Subscriber SSN _____

Address _____

Group Name _____ **Group Number** _____

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

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

The completed letter may be sent to: Membership Accounting, Health Advantage, P. O. Box 8069, Little Rock, Arkansas 72203-8069, or faxed to: 501-301-6869 (Customer Accounts).

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, contact Customer Service at 1-800-843-1329.

STUDENT VERIFICATION INFORMATION

Member is not a full-time student. Date member was no longer student _____
(Member's coverage will be terminated according to the terms of the group contract)

Member is full-time student at an accredited institution:

Member Name (Student) _____ Date of Birth _____ Date Current Semester began _____

Name of Educational Institution _____

City _____ State _____ Zip Code _____ (Educational Institution)

Number of Hours Enrolled _____ Graduation date if known _____ Phone Number of Educational Institution _____

Subscriber Signature

Date

5/2004

FAX 501-301-6869