

101 S. Jefferson St.
Roanoke VA 24011
Phone: (540) 345-2721
Fax: (540) 342-0282

Benefit Plan Administrators

DEPENDENT STUDENT STATEMENT

Employee Name: _____

Employee SSN: _____

Group Number _____

Please complete section one of this form, then have section two completed by the institution. Also, please provide a copy of the school schedule which must include the total credit hours for each semester. **Please notify this office immediately if this student status changes any time during the year.**

1) Is student covered by any other medical plan? YES NO

If so, please provide the name, number and address of the plan(s):

2) I certify that _____ is _ years of age and is a full-time student in an institution of higher learning at _____

_____.

He/She is currently enrolled in:

Spring _____

Fall _____

Signature of school official

Printed name of school official

Date

****Please fill in below or attach a copy of the student's current schedule, which must include the total credit hours for the current semester****

Total Credit Hours Needed For Full-Time Status: _____.

Total Credit Hours Per Semester _____.