



# DEPENDENT STUDENT CERTIFICATION FORM

## Section One: To Be Completed by Subscriber

Subscriber's Certificate Number:

Subscriber's Name:  (Last Name)  (First Name)  (MI)

Subscriber's Address:  (Street)  
 (City)  (State)  (Zip Code +4) -

Student's Name:  (Last Name)  (First Name)  (MI)

Student's DOB:  (Month) -  (Day) -  (Year) Student's Social Security No:  -  -

Name of School:

Address of School:  (Street)  (City)  (State)  (Zip Code)

Semester:  Fall  Winter  Spring  Summer  (Month) -  (Year) Year of Study (Circle One): 1st 2nd 3rd 4th 5+

Has student served in the Armed Forces: Yes  No  If Yes: From  (Month) -  (Day) -  (Year)

**DEFINITION OF DEPENDENT STUDENT:** A full-time dependent student is a person who meets all of 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.

I certify that my dependent, \_\_\_\_\_ meets all of the following requirements for eligibility as a dependent student

	Yes	No
A. 19 years of age or older	<input type="checkbox"/>	<input type="checkbox"/>
B. Unmarried	<input type="checkbox"/>	<input type="checkbox"/>
C. Receives at least half of his/her support from the employee or retired employee	<input type="checkbox"/>	<input type="checkbox"/>
D. Is a full-time student in an accredited secondary or preparatory school or college	<input type="checkbox"/>	<input type="checkbox"/>
D. Expected date of graduation _____/_____/_____		

I agree to advise GHI promptly of any changes in my child's dependent student status.

\_\_\_\_\_  
 (Subscriber's Signature) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 (Date)

## Section Two: To be Completed by Authorized Person in the Registrar's Office of the Student's Educational Institution (Affix the institution's Seal or Stamp Where Indicated Below)

The student named in this form may be eligible for health/dental coverage under his or her parent's health/dental insurance plan. See Section One, above, for definition of dependent student. In order for GHI to determine a student's eligibility, please complete the following information:

1. Is the student enrolled full-time? Yes  No
2. Student's program of study? \_\_\_\_\_
3. Student's expected degree or diploma? \_\_\_\_\_
4. Is \_\_\_\_\_ Accredited Yes  No   
 (Name of Institution)
5. Registrar's Telephone Number: \_\_\_\_\_

**Affix Institution Seal/Stamp Here**

\_\_\_\_\_  
 Authorized Signature/Title

**Mail Validated Form to:** GHI  
 P.O. Box 2821  
 New York, NY 10116-2821

*Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing 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.*