

STUDENT COVERAGE QUESTIONNAIRE

1. Employee's Name _____
2. Employee's identification number (often, the Social Security number) _____
3. Dependent's name _____
4. Dependent's birth date ____/____/____
5. Dependent's relationship to the employee _____
6. Is the dependent: single? married? divorced? separated?
7. Is the dependent employed? Yes Full-time Part-time No
8. List any other group insurance program the dependent is covered under _____
9. School name and address _____

10. Type of school (college, trade, etc.) _____
11. Is the student full-time or part-time? _____
12. Dates of the current school term _____
13. What is the expected date of:(a) course completion _____
(b) graduation _____

I hereby certify that the above is correct to the best of my knowledge.

Signature of employee

Date

****SCHOOL CERTIFICATION****

NOTE: After completing the above information, forward this form to the school for their certification of questions 9 through 13.

**Signature of Registrar of School
and imprint of school seal**

Title/Date

PO BOX 3509 / CHURCH STREET STATION / NEW YORK / NEW YORK 10008-3509