TUFTS Health Plan

No one does more to keep you healthy.

Student Dependent Certification Form

Subscriber's name: ____

Subscriber's Tufts Health Plan ID number: _________-____________-____________

I certify that: ___________________________ ____________________ ______/______/______

(Name of student dependent) (Social Security Number) (Date of Birth)

is my or my spouse's* unmarried child who:

(Please check one)

❑ **Is a FULL TIME STUDENT** (as defined by the educational institution)

at: ____ (Name of accredited educational institution)

____ (Institution address)

____ (Registrar's telephone number)

for the Spring/Fall (Circle one) ____________________ (Year) semester

which begins ______/______/______ and ends _____/______/______

(example: 01/08/2004 through 06/04/2004)

Expected date of graduation: _________/____________

❑ **Is no longer a full-time student**

I further certify that the information I have provided above is true and correct, and that I understand that:

- I must notify Tufts Health Plan immediately if there is any change in my dependent's student status; i.e., a change from full-time to part-time status, a transfer to another school, or dropping out of school.
- Tufts Health Plan may contact the educational institution and take any other steps it feels necessary to verify the accuracy of the information I have provided.
- **If there is any misrepresentation in the information I have provided, Tufts Health Plan may end my dependent's coverage and my whole family's coverage, and may seek any other legal remedies available.**

- **My dependent's coverage will be ended without any additional notice if I do not return this form within 30 days.**

Subscriber's signature:____ Date: ______________________

Please return this signed form to:
Tufts Health Plan
Commercial Enrollment and Premium Billing Department
P. O. Box 9186, Watertown, MA 02471-9186

* Or Domestic Partner, if the employer offers coverage for Domestic Partners

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