

INDIANA STATE UNIVERSITY
OFFICE OF STAFF BENEFITS ADMINISTRATION
REQUEST FOR STUDENT CERTIFICATION

Instructions: Please complete one form for each dependent over age 19 to be certified for health coverage as a student: **Please return this form by November 30, 2008.**

Member and Account Identification Member's Name: _____
Member's Identification Number: _____
Member's Account Number: _____ **N91263**

Dependent Identification Dependent Name: _____
Relationship to Member: _____
Date of Birth: _____

Dependent Status Single ___ Married ___ Divorced ___ Separated ___
Employed full-time _____ Employed part-time _____
Is this dependent listed as a dependent for Federal Income Tax purposes? Yes _____ No _____ (2007 tax form)

Student Enrollment Period to Certify **Spring Semester 2009 (school documentation)**
Beginning Semester Date _____ Ending Semester Date _____
Name & address of Educational Institution _____

Statement I certify that the above named dependent will be a full-time student (with 12 credit hours minimum per semester) at an accredited college or university, trade or secondary school. I will provide proper proof of student enrollment for certification (such as a schedule of classes or a copy of tuition statement) and a copy of my tax statement.

Employee's Signature _____

Date Signed _____

No Longer Eligible The above dependent will not be a full-time student and/or a tax-dependent as of _____ because _____ and should be deleted from my coverage.

Employee's Signature _____

Date Signed _____

Important Information **When your dependent child is no longer a full-time student, you must notify Staff Benefits within 30 days.** Failure to do so might result in dependent(s) not being able to continue dependent health coverage. If you have any questions about this, contact Staff Benefits Ext. 4150

Return form to: Indiana State University
Staff Benefits
210 North 7th Street, 300 Rankin Hall
Terre Haute, IN 47809