

SECTION ONE: TO BE COMPLETED BY SUBSCRIBER

PLEASE NOTE: You must submit full-time student status EVERY semester in order for your dependent's coverage to remain in effect.

Subscriber's Group Number		Subscriber's Social Security / I.D. Number	
Subscriber's Name			
Subscriber's Address			
City	State	Zip Code	
Student's Name		Student's D.O.B.	
Name of School			
Address of School			
City	State	Zip Code	

Semester:	<input type="checkbox"/> Fall			<input type="checkbox"/> Winter			<input type="checkbox"/> Spring			<input type="checkbox"/> Summer		
	Mo./Yr. ____/____			Mo./Yr. ____/____			Mo./Yr. ____/____			Mo./Yr. ____/____		
	Year of Study	1	2	3	4	5+	Has student served in the Armed Forces? Yes <input type="checkbox"/> No <input type="checkbox"/>			If "Yes", from when:		

Definition of a Dependent Student: A full-time student is a person who meets all of the following conditions:
 (a) He/she is at least 19 years of age; (b) unmarried; (c) receives at least half of his/her support from the employee or member; and
 (d) is enrolled full-time in an accredited secondary or preparatory school or college.

I certify that my dependent, _____, meets all of the requirements for eligibility as a dependent student.

- A. 19 years of age or older: Yes No
- B. Unmarried: Yes No
- C. Received at least half of his/her support from employee or retired employee: Yes No
- D. Is the full-time student in an accredited secondary, preparatory school or college: Yes No
- E. Expected date of graduation: Month: _____ Year: _____

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

Subscriber's Signature	Date
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SECTION TWO: TO BE COMPLETED BY AUTHORIZED PERSON IN THE REGISTRAR'S OFFICE OF THE EDUCATIONAL INSTITUTION

The student named in this form may be eligible for dental coverage under his/her parent's dental insurance plan. See section one (above) for definition of dependent student. In order for Healthplex 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 your institution accredited? Yes No
5. Registrar's Telephone Number: _____
6. Authorized Signature/Title: _____

Please mail, fax or email this completed form to:
 Healthplex, Inc.
 Attn: Enrollments Department
 333 Earle Ovington Blvd., Suite 300
 Uniondale, NY 11553-3608
F 516 227 0582
E Enrollments@Healthplex.com

Affix Institution Seal/Stamp Here

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

***A copy of this form can be obtained at www.healthplex.com**