FULL-TIME STUDENT STATUS VERFICATION FORM

Employer Name: ____________________________________ **Group #:** __________________

Employee Name: ____________________________________ **SSN:** _____________________

Dependent Name: ____________________________________ **DOB:** _____________________

Based on the above named dependent's age, coverage under the employer's health plan is contingent on full-time attendance at an accredited college or university. In order for our office to be properly informed, please sign the authorization below and forward this form to the school the above named dependent attends. Claims for group health plan benefits will be denied until this form is completed and returned to our office. If the dependent will not be attending school on a full-time basis, he or she is not eligible for enrollment in the health benefit plan at this time.

This signed form authorizes information relative to the student status of the above named dependent to be released to TRISTAR Benefit Administrators.

____________________________________ ______________________________________

Signature of student *Signature of employee/insured*

This section to be completed by the college or university.

1. Is the above reference dependent a full-time student at your institution? Yes No
2. If yes, as of what date? ___________________
3. What is the expected date of graduation? _________________
4. Is there medical insurance coverage for this student under any group health insurance plan provided by your institution? Yes No
5. If yes, who is the insurance carrier? ____

   Insurance carrier name and address

   ____

   Policy # *Student's effective date*

____________________________________ ______________ ___________________________________

Signature *Date* *Title*

Name of institution __________________________________

Telephone number __________________________________

Please return this form to:

TRISTAR Benefit Administrators
Attention: Eligibility
PO Box 65887
West Des Moines, IA 50265-0887