BlueCross BlueShield of Texas
P.O. Box 655730
Dallas, Texas 75265-5730

Student Certification and Statement of Dependency

☐ Student Certification ☐ Statement of Dependency (see reverse side)

Please provide the following information concerning the member of your family who is eligible to continue coverage as a "student dependent." To continue coverage beyond the maximum age limit specified in your contract for dependents, this form must be received within 60 days of the affected dependent becoming eligible for coverage as a "student dependent."

IMPORTANT – If PCP required for your benefit plan, please list your student's PCP designation. If you decline, one could be assigned for you.

1. Group No. _____ Section No. _____
2. Health Certificate No. _____ Dental Certificate No. _____
3. Employee Name _____
4. Dependent's Name _____ Date of Birth _____ / _____ / _____
5. Dependent's Address _____
6. PCP Name _____ PCP# and ID# _____
7. Dependent's Sex _____ Relationship to Employee _____
   If relationship is other than a natural child of the Employee, complete the form on the reverse side.
8. Is dependent: ☐ Single ☐ Married ☐ Divorced ☐ Separated
9. Does dependent satisfy Internal Revenue Service requirements for dependency (i.e., more than 50% financial support is provided, the dependent attends school full time for a minimum of five (5) months in a calendar year, etc.)?
   _____Yes _____No
10. Is dependent covered under any other employer group insurance or prepayment program?
    _____Yes _____No If **yes**, please provide the following:
    Name of other Insurance Company
    Name of Policyholder
    Policy Number Effective Date_____/_____/_____
    Mo. Day Yr.
11. Name of school in which dependent is enrolled _____
    _____
12. Address of school _____
13. Type of school (Example: High School, College, Trade, Etc.) _____
14. Is student considered a full-time student according to requirements of the institution attended?
    ____Yes ____No
15. On what date did the dependent become a full-time student? _____/_____/_____
    Mo. Day Yr.
16. Course of study _____

I hereby certify that the above information is correct and authorize release of any information requested with respect to this certification. I also certify that the dependent child named is a full-time student in an accredited institution. I also understand that if the above listed dependent child ceases to be eligible as a student, I must notify my employer who will notify Blue Cross and Blue Shield of Texas or HMO Blue® Texas to cancel coverage on the dependent child.

_____ _____
(Signature) (Date)

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

BlueCross BlueShield of Texas

STATEMENT OF DEPENDENCY

Group/Section No. _____ Health Certificate # _____ Dental Certificate # _____

This statement is for the purpose of determining dependent eligibility for coverage under my membership, and I request to add the child(ren) listed below to my coverage:

Name of Dependent	Date of Birth	Relationship

If any dependent child listed above exceeds the age limit stated in your employer's contract and is a student, also complete the form on the reverse side.

Signature of Employee _____

The State of Texas, County of _____

Sworn to and Subscribed Before Me by the said _____
Name of Employee

this the _____ day of _____, 20____. _____
Signature of Notary Public
In and for the State of Texas

_____
Print Name of Notary Public