Annuitant Health Care Program
Student Certification Form

*This form **and the required enrollment verification** must be returned to the Central Benefits Office to ensure health care coverage for the student.*

Annuitant Information

Annuitant's Name _____

University _____ Personnel Number _____ Date of Birth _____

Address: Street _____

City _____ State _____ Zip Code_____

Daytime Telephone Number (_____)_____ Email Address _____

Dependent Child Information

Dependent Student's Name_____

Dependent Student's Date of Birth _____ (Eligible dependents may be covered up to the age of 25.)

Relationship to Annuitant: ❒ Natural/Adopted Child ❒ Stepchild ❒ Other (explain) _____

If dependent student is not a blood descendent of the first degree or adopted, does student reside with you when not attending classes on a full-time basis? ❒ Yes ❒ No

Dependent Student's Marital Status ❒ Single ❒ Married ❒ Divorced

Is dependent employed during school year? ❒ Yes ❒ No

If yes, is he/she employed ❒ Full-time ❒ Part-time

Current Semester Attending _____

Name of School Which Student Attends _____

Type of School: ❒ High School ❒ College ❒ Trade School ❒ Other (explain) _____

Expected Date of Graduation _____

Type of Student

❒ Full-time Number of credit hours this semester _____ **required field

❒ Part-time Number of credit hours this semester _____

❒ ***Not Enrolled***

❒ ***Withdrawal*** ***Date (if applicable)*** _____

❒ ***Graduated*** ***Date (if applicable)*** _____

Registrar's Address: Street _____

City _____ State _____ Zip Code _____

Registrar's Telephone Number (____) _____

(OVER ⇨)

I certify that the above-named student qualifies as my dependent child, and I agree to provide proof of relationship and age as required. I further acknowledge that if the above-named dependent ceases to be a full-time student, it is my responsibility to immediately notify the Central Benefits Office at RetireeBenefitHelp@passhe.edu. If I fail to notify the Central Benefits Office within 60 days of the date the dependent ceases to be a full-time student, I further acknowledge that the student will be unable to continue this group insurance on a direct-pay basis under the provisions of the federal law known as COBRA.

The information set forth herein is obtained from the student's academic records ***and/or an Enrollment Verification Certificate from the National Student Clearinghouse and is an accurate reflection of the student's enrollment status.***

Annuitant's Signature _____ Date _____

Note: Eligibility for benefit coverage as a student dependent and continuance of this coverage is subject to periodic evaluation and recertification. Should student status or information on this certification form change at any time, benefit coverage will be reconsidered.

*Health coverage for up to one year will be provided upon written certification from a college student's treating physician that the student is suffering from a serious illness or injury requiring a medical leave of absence. The one-year period begins with the first day of medically necessary leave of absence and may end before the year is up if coverage would terminate for some other reason.

Enrollment Verification

Annuitant must provide either:

1) A copy of Enrollment Verification from the National Student Clearinghouse available through http://studentclearinghouse.org. (Note: A fee may be charged for this service.)

OR

2) A letter from the Registrar of the Institution the student is attending confirming enrollment semester and status relative to credits being pursued.

OR

3) If Enrollment Verification Certificate from the National Student Clearinghouse is not available:

The information set forth herein is obtained from the student's academic records and is an accurate reflection of the student's enrollment status.

Educational Institution Seal

_____
Registrar's Signature

_____
Date

To ensure health care coverage for the student, return this form, along with the required enrollment verification to: ***Pennsylvania's State System of Higher Education***
Office of the Chancellor
Attention: AHCP Benefits
2986 North Second Street
Harrisburg, PA 17110