Healthplex®
Leadership in Dental Plans

DEPENDENT STUDENT CERTIFICATION FORM

Section One: To Be Completed by Subscriber

Subscriber's Group Number _____ Subscriber's Social Security Number _____

Subscriber's Name _____
Last Name First Name

Subscriber's Address _____
Street Address

_____
City State Zip Code

Student's Name _____ Student's D.O.B. _____
Last Name First Name

Name of School _____

Address of School _____
Street Address

_____
City State Zip Code

Semester:

☐ Fall		☐ Winter		☐ Spring		☐ 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 ☐ No ☐	If Yes, from when:	

DEFINITION OF A DEPENDENT STUDENT:

A full-time student is a person who meets all of the following conditions: He/she is at least 19 years of age; unmarried; receives at least half of his/her support from the employee or member, and, 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 of 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 a 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

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:		

Affix Institution Seal/Stamp Here

Mail/Fax Validated Form to:

Healthplex
Enrollment Department
333 Earle Ovington Blvd., Suite 300
Uniondale, NY 11553-3608
Fax: 516-227-0582

Any person who knowingly and with intent to defraud any insurance company of other person files a statement containing any false information or conceals information to mislead any fact thereto commits a fraudulent insurance act which is a crime.

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