HEALTHPLEX
THE DENTAL BENEFIT EXPERTS℠

DEPENDENT STUDENT CERTIFICATION FORM

Section one: To be Completed by Subscriber

PLEASE NOTE: You must submit full-time student status <u>EVERY</u> 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:

☐ 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: (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

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**