

Student Status Form

DATE _____

Dear Employee:

Our records indicate that the dependent named below has reached age nineteen (19). To provide or continue coverage of the dependent, please answer the following questions and mail the completed form to:

**Administration Department
Medical Claims Management Corporation
PO Box 12995
Charlotte, NC 28220-2995**

Employee: _____

Employee Social Security Number: _____

Employer: _____

Dependent: _____

1. Is this dependent currently enrolled as a full-time student at an accredited university or college?
Yes _____ No _____

2. What are the beginning and ending dates of this current enrollment period? (Semester or quarter)

Beginning Date: _____

Ending Date: _____

3. How many credit hours enrolled for this current enrollment period? _____

4. Give the name, address and telephone number of the college or university.

Phone Number: _____

5. What is this dependent's social security number?

Social Security #: _____

6. If not currently enrolled in school, what was the last date the dependent attended school?

Date: _____