PROOF OF STUDENT STATUS

COMPANY:_____ DATE:_____

EMPLOYEE:_____

STUDENT NAME:_____ STUDENT DATE OF BIRTH:_____

THIS IS TO CERTIFY THAT THE ABOVE NAMED STUDENT IS A FULL TIME STUDENT ATTENDING AN ACCREDITED SCHOOL.

NAME OF SCHOOL:_____

ADDRESS:_____

SEMESTER/QUARTER (must include begin and end date):_____

NUMBER OF UNITS:_____

I understand that if the above information is not complete or correct, this coverage could be retroactively terminated. I understand that I or my dependent child must inform the human resource department of any changes to the above information within 60 days of the change. If I do not notify my human resource department within 60 days of a change, COBRA coverage may not be offered by the employer.

SIGNATURE OF INSURED:_____ DATE:_____