SCHOOLCARE

Full Time Student on Medical Leave of Absence
Request for Continuation of Coverage as Dependent for Up to One Year

Part I. To be completed by subscriber. PLEASE PRINT.

I certify

that_____ has been attending_____
(name of dependent) (name of college or university)

located in _____from _____through_____.
(date) (date)

Required: When submitting this completed form, include original letter from the college or university, with raised seal, signed by an appropriate official certifying the above information. The letter must also state that the dependent is or was a full time student immediately preceding this request for Continuation of Coverage as a Dependent. Full time student is defined as 12 credits or more per semester.

By signing below, I agree that any misrepresentation on this form or accompanying documents will result in denial of benefits for the dependent named above.

Signature_____ Date_____ ID Number U-_____

Name (Please Print)_____

Part II. To be completed by attending physician.

I certify that_____ is unable to maintain full time status at the above college or university. I am attaching to this form on official letterhead a description of the illness, including appropriate DX and CPT codes and the anticipated beginning and ending dates that the student will be unable to attend full time.

Signature_____ Date_____

Name (Print)_____

To the subscriber (parent): Submit this form and other required information (letter from college/university and physician's letter) to

SCHOOLCARE
Lisa Duquette, Privacy Officer
370 Harvey Rd Ste 4
Manchester, NH 03103

Questions? Contact Lisa Duquette at 800-562-5254, ext. 305.