

SCHOOLCARE HEALTH BENEFIT PLANS

P.O. Box 1300
 Manchester, NH 03105-1300

Questionnaire for Verification of Dependent Eligibility

DATE	SUBSCRIBER'S NAME (EMPLOYEE)	DEPENDENT'S NAME
NAME OF HEALTHPLAN:	HEALTHPLAN CODE	ID NUMBER
SchoolCare	3206140	
EMPLOYER NAME		

Please complete Section A or B, and sign/date this Questionnaire. Return the Questionnaire with the appropriate documentation to SchoolCare at the address above.

A. Full-Time Student Verification

____ Named dependent qualifies for continued coverage under the plan terms (unmarried, primarily supported by the employee, and enrolled in school as a full-time student). Please return this Questionnaire with one of the following forms of verification:

- A copy of the current semester official claim schedule reflecting full-time student status &/or total credit hours; OR
- A signed statement from the Registrar or Dean of Students verifying full-time status; OR
- A copy of the current semester tuition bill showing full-time student status &/or total credit hours

____ Named dependent does not qualify for continued coverage under the plan terms.

B. Handicapped/Disabled Dependent Verification

____ Named dependent qualifies for continued coverage under the plan terms (disabled/hadicapped and incapable of self-support). Please return this Questionnaire with the following documentation from the attending physician:

- Date of initial occurrence;
- Diagnosis;
- Degree/Severity of disability;
- Current medications, treatments, therapies;
- Prognosis of disability;
- Statement of patient's ability to be self-supporting; AND
- Attending physician's name, address and telephone number

____ Named dependent does not qualify for continued coverage under the plan terms.

Authorization/Release of Information: I certify that all the information I have provided is true and correct to the best of my knowledge. A copy of this authorization shall be valid as the original. I hereby authorize any insurance company, administrator, prepaying organization, employer, pharmacy, hospital, physician, or organization to release all information with respect to myself or my dependents that may have a bearing on the eligibility of coverage.

Verification of dependent eligibility will be requested periodically.

Signature of Employee/Subscrber: _____

Date: _____