

# STUDENT CERTIFICATION

**This student certification is required annually.**  
If you do not return this form, your dependent could lose health care coverage.  
A break in coverage now could mean waiting periods for pre-existing conditions later.

Dependent's name:

Date of birth:  
Certificate No:  
Group No:

Choose one of the following options and check the appropriate box. Please complete and return this form immediately to your Group Benefits Administrator. If you have individual coverage, please return to our Account Services department: BCBSVT, P.O. Box 186, Montpelier, VT 05601-0186

## Option I: STUDENT CERTIFICATION

My dependent still qualifies for student status and should remain covered under my membership.

I certify that \_\_\_\_\_ (student's name) is unmarried, under age 25, and enrolled full-time (for 12 or more credits per semester) at \_\_\_\_\_ (school name) for the semester beginning \_\_\_\_\_ (date).

## Option II: CANCELLATION

Please cancel my dependent's membership. He or she no longer qualifies for student status (and doesn't meet the criteria for an incapacitated dependent) and does not choose to convert to an individual policy.

## Option III: CONTINUATION OF GROUP BENEFITS

My dependent will remain in the group through continuation coverage provided by state or federal law. I have contacted my employer to elect such continuation coverage and will file an Application and Change Form.

## Option IV: CONVERSION TO DIRECT-PAY COVERAGE

My dependent no longer qualifies for student status as of \_\_\_\_\_ (day/month/year). He or she will take advantage of Blue Cross and Blue Shield of Vermont's conversion privilege and has completed the application for individual direct-pay coverage on the back of this form.

If you have any questions concerning this notice, please call our Customer Service Department, Monday through Friday, 8:00 a.m.- 4:15 p.m. Vermont Health Partnership subscribers should call (800) 344-6690. All others should call (800) 247-2583 in Vermont; (800) 457-6648 outside Vermont.

Subscriber's Signature \_\_\_\_\_ Date \_\_\_\_\_



**BlueCross BlueShield  
of Vermont**

An Independent Licensee of the Blue Cross and Blue Shield Association.

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