BENEFIT MANAGEMENT SERVICES

Benefit Management Services
P.O. Box 98044
Baton Rouge, LA 70898-9044

DEPENDENT CERTIFICATION

DATE OF REQUEST _____

☐ **FIRST REQUEST** ☐ **SECOND REQUEST** ☐ **THIRD REQUEST**

Complete for ☐ Fall Semester ☐ Spring Semester ☐ Both

Dependent Certifications are used to determine the eligibility of college age dependents. This form is to be completed at the beginning of each semester. The requirements for college age dependents to remain on the plan are: enrollment in the current semester and they must be classified as a full-time student. We must receive documentation from the school in attendance which includes the child's name, semester in attendance, including dates, and the number of hours enrolled. This information must be completed and returned to our office within 30 working days of the receipt of this letter. **Failure to complete, sign and return this form along with the required documentation will result in non-payment of claims for any college age dependent.**

Policy Holder's Name	Plan Participant ID No.	Group Number

1. Dependent's Name	Date of Birth	Age	Sex ☐ M ☐ F

2. Dependent's marital status: ☐ Single ☐ Married

3. ☐YES ☐NO Is dependent covered under any other insurance contract? If YES, give name of company and policy number.

Company Name	Policy No.

4. ☐YES ☐NO Does dependent rely on you for financial support?

5. ☐YES ☐NO Does dependent reside with you?

6. ☐YES ☐NO Is dependent a full-time student? If no, what was the date of the last semester completed and school dependent attended?

Spring Semester _____ To _____

Fall Semester _____ To _____

Name, Address and Telephone Number of School Now Attending

8. ☐YES ☐NO Is dependent mentally or physically incapacitated? If yes, please attach medical documentation from your doctor with an explanation of:

A. Diagnosis of condition(s) causing incapacitation
B. Date patient/dependent first became incapacitated
C. Anticipated length of incapacitation
☐ Additional information needed

Comments:

CERTIFICATION BY EMPLOYEE – READ CAREFULLY – THIS SECTION MUST BE SIGNED BY EMPLOYEE

I, _____, certify that the foregoing information is correct to the best of my knowledge, and agree to the following:
(Please print name of subscriber)

1. I will inform Benefit Management Services of any changes affecting the above dependent's status.
2. I agree to refund to Benefit Management Services any monies paid by Benefit Management Services on the above dependent, should that dependent at any time not qualify under the above guidelines and during that period of disqualification Benefit Management Services paid monies for the above dependent based on the certification.
3. I authorize Benefit Management Services to verify, directly or indirectly, or through its authorized agents, any of the foregoing information.

_____ **X** _____

Date Employee's Signature