INSURANCE PROGRAMMERS, INC.
P.O. Box 5817
Wallingford, CT 06492-7617
(800) 446-8646 (800) 827-1703

STUDENT STATUS - REQUEST FOR INFORMATION

In order to consider benefits for your dependent child, who would not otherwise be eligible for coverage under your plan, we require the following information as verification of full-time Student Status. We may require completion of this form up to twice a year dependent upon when services are rendered. **IF A DEPENDENT CHILD WILLINGLY BECOMES INELIGIBLE FOR COVERAGE AS A FULL-TIME STUDENT, THEY WILL NOT BE ELIGIBLE TO RECEIVE BENEFITS UNTIL THE DAY THEY RETURN TO SCHOOL AS A FULL-TIME STUDENT.**

Proof of Student Status is required to process claims for services rendered between:

January 1st and August 31st - Spring Semester for the Year ________ ___
September 1st and December 31st - Fall Semester for the Year ________ ___

NOTE: Proof of Student Status is required for EACH period during which services are rendered.

PLEASE NOTE: WE CAN ONLY ACCEPT STUDENT STATUS VERIFICATION FOR THE CURRENT OR PRIOR SEMESTER(S). PRE-REGISTRATION FORMS, TUITION BILLS, CLASS SCHEDULES, REPORT CARDS & STUDENT I.D. CARDS WILL NOT BE ACCEPTED. ANY FORM FOR THE CURRENT SEMESTER MUST BE COMPLETED AFTER YOUR DEPENDENT CHILD STARTS CLASSES.

The following information is required. Parts A and B must be completed in full. PLEASE PRINT.

PART A - TO BE COMPLETED BY THE INSURED

Please check all coverages that apply for this dependent:
(For plans administered by Insurance Programmers) ☐ Dental ☐ Vision

Name of Dependent Student: ____________________
Student's Social Security Number: ____________________
Name of Insured: ____________________
Insured's Social Security Number: ____________________
Name of Insured's Employer: ____________________
Signature of Insured: ____________________ Date: ____________

PART B - TO BE COMPLETED BY THE ACCREDITED EDUCATIONAL INSTITUTION

Name of School: ____________________
Name of Student: ____________________
who is registered as a FULL-TIME ______ or PART-TIME ______ student *{please check one}*
for the Fall, ________ or Spring, ________ semester which *{please enter year}*
begins ____/____/______ and ends ____/____/______ ***{please enter month/day/year}***
Expected date of graduation: ________/______ *{please enter month/year}*
Signature of Registrar or Bursar ____________________ Date: ____________
Imprint School Seal Below (REQUIRED):

Please return this completed form to:

INSURANCE PROGRAMMERS, INC.

P.O. Box 5817
Wallingford, CT 06492-7617

Studstat2000
Revised: 08/00 (.