Student Certification for Overage Dependent

Group Name **Somerset County Public Schools**

Overage Dependent's Name: _____

Overage Dependent's Date of Birth: _____

Name of School: _____

Address of School: _____

_____

I certify that my son/daughter, is unmarried, is financially dependent, and is a full-time student enrolled in an accredited school.

His/her enrollment at the above school began: Month _____ Day _____ Year _____

The expected graduation date is: Month _____ Year _____

Beginning date current semester/trimester: mm/dd/yy _____ Ending date current semester/trimester mm/dd/yy _____

I understand that his/her protection under my coverage will terminate (as defined in the Certificate/Evidence of Coverage) on:

- The end of the calendar year the full-time student attains age 23
- the last day of the calendar month in which he/she ceases to be a full-time student

If your Dependent no longer qualifies for coverage, please immediately contact Brenda Henderson in the Finance Office.

_____ _____

Date **Subscriber Name - Printed**

_____

Subscriber Signature

_____

Subscriber Identification Number

Please return this form to: **Brenda Henderson in the finance office within 30 days**

Note for Finance Department: Please forward all forms to the Salisbury Regional CareFirst Office for processing.