ncas®
The Team Approach to Benefit Administration

Student Certification

For an Over-age Dependent

Employer:	Subgroup:
Employee:	Identification Number:

I hereby certify that my dependent child under the AMHIC PPO, Network Only, Dental and/or Vision Plan, _____

is unmarried, is financially dependent on me for support, and is a full-time student enrolled in an accredited school. His/her date of birth is _____.

He/She attends:

School Name:
Street Address:
City, State, Zip:

His/her enrollment at the above school began _____; the expected graduation date is _____.
Month/Day/Year
Month/Year

I understand that his/her protection under my coverage will terminate the last day of the month that the dependent turns age 19, or anytime the dependent is not enrolled as a full time student, up to age 26. I further understand that I must notify my employer of any change in my son/daughters full time student status within 60 days of the date of the event or the date, on which coverage would terminate, whichever is later.

I attest that the above information is truthful to the best of my knowledge.

Employees
Signature: _____ Date: _____

Return completed form to:
Diane Sedor
AMHIC
Fax: 703-760-6015