



FOR HPS USE ONLY

Approved _____ Effective Date ___/___/___

Expiration Date ___/___/___

Denied _____

Reason _____

Reviewed by: _____

Date ___/___/___

VERIFICATION OF STUDENT ELIGIBILITY

PLEASE PRINT AND ANSWER ALL QUESTIONS, forwarding this to the educational institution to complete the second section and return to Health Plan Select.

Name of Insured _____ Insured's Social Security # _____

Address _____ Telephone Number (_____) _____

Place of Employment _____

Name of Student _____ Student's Social Security # _____

Relationship to Insured _____ Student's Date of Birth ___/___/___

Name of Educational Institution Student is Attending _____

Address of School _____

City, State, Zip _____

I understand that I must notify HPS when my dependent is no longer a full-time student, withdraws from school, is put on a medical leave of absence from school or graduates; and I understand that my health plan may, at times, certify with the educational institution my dependent is attending that he/she is enrolled full-time. I have read the important information on the attached letter.

Signature of Insured _____ Date _____

II. EDUCATION CERTIFICATE (COMPLETED BY INSTITUTION)

The above student has been accepted or is currently enrolled in our educational institution as a **Full-Time Student**:

a. FALL _____ WINTER _____ SPRING _____ SUMMER _____ QUARTER or SEMESTER _____
(enter year) (enter year) (enter year) (enter year) (circle one)

Classes begin on _____ and end on _____. Expected date of graduation: Month _____ Year _____

OR

b. Part-time _____ for the quarter/semester of _____. c. Minimum fulltime-credit hours _____.

d. Is the student on a medical leave of absence? Yes _____ No _____

If yes, leave approved From _____ To _____

Name of Educational Institution Name of Registrar

Name of Registrar

Date

PLEASE AFFIX SCHOOL SEAL

Signature of Registrar or Designee

**Return application to:
Health Plan Select, 295 W. Clayton Street, Athens, GA 30601
Fax (706) 549-8004**