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.

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