



# New York City Employees PPO (NYCE PPO) Dependent Student Certification Form

Mail form to: PO Box 2821, New York, NY 10116-2821

Subscriber Identification Number:

Student's Name:

Student's Date of Birth (DOB):

I certify that my dependent student listed below meets all of the following requirements for eligibility as a dependent student.

- A. 19 years of age or older  Yes  No
- B. Unmarried  Yes  No
- C. You provide more than 50% support for this dependent student  Yes  No
- D. Is a full-time student in an accredited secondary or preparatory school or college or is eligible for a dependent student extension.\*  Yes  No
- E. Expected date of graduation: \_\_\_\_/\_\_\_\_/\_\_\_\_

**DEFINITION OF DEPENDENT STUDENT:** A full-time dependent student is a person who meets all the following conditions: They are at least 19 years of age, unmarried, receive at least half of their support from the employee or member, and are enrolled full-time in an accredited secondary or preparatory school or college.

If a covered dependent student is required to take a medically necessary leave of absence from school because of illness or injury, the dependent is eligible for continued health insurance coverage for the lesser of:

- One (1) year after the first day of the leave of absence or last date of attendance in school, whichever is later; or the date that coverage would otherwise terminate for the dependent student under the terms of the policy.
- The treating physician must certify to NYCE PPO that the dependent student is suffering from a serious illness or injury and that the leave of absence is medically necessary. During the continuation period, the dependent student will be entitled to the same benefits as if the dependent student was enrolled in school and not on the medically necessary leave of absence.

**TO BE COMPLETED BY THE SUBSCRIBER**

Employer Name

Subscriber Name

Subscriber ID #

Student Name

School Name

School Address

School City  State  ZIP Code

School Phone  -  -  The semester begins on / /  and ends / /

I confirm that the above-named dependent is registered as a:  Full-time student  Part-time student

Student is in an accredited educational institution for the:  Fall  Winter  Spring  Summer semester

If no longer attending: graduation date: \_\_\_\_\_ or date last attended: \_\_\_\_\_

\*A limited extension is available for dependent students no longer enrolled full-time to provide coverage during semester breaks. Please contact your Health Benefits Administrator for more details.

I attest that the information shown above is true and complete. I understand that failure to complete this form may result in a delay, denial, or termination of coverage for the above-named dependent. I understand that NYCE PPO reserves the right to ask for more information as proof of the above-named dependent's full-time student status. I agree to advise NYCE PPO promptly of any changes in my child's dependent student status.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim concerning any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and also be subject to a penalty not to exceed five thousand dollars and the stated value of the claims for each such violation.

Subscriber's Signature \_\_\_\_\_ Date \_\_\_\_\_