Full Time Student Verification Questionnaire

Member Certification

Section 1

Employee Name:

Employee Insurance ID Number:

Dependent Name:

Dependent SSN:

Is this dependent married? ☐ Yes ☐ No

In the armed forces? ☐ Yes ☐ No

Is this dependent currently attending school full time? ☐ Yes ☐ No

Will this dependent attend school next term full time? ☐ Yes ☐ No

Signature: Date:

School Certification

Section 2

School Name:

Address:

City: State: ZIP:

Credit hours enrolled this term: Estimated Graduation Date:

Please attach a copy of the current semester school schedule or course registration paperwork