STUDENT CERTIFICATION FOR HEALTH PLAN ENROLLMENT

Employee Name		Empl ID#
Email Address	Work Phone	Home/Cell Phone

Student's Full Name	Student's Birthdate
School Student is Attending	Anticipated Graduation Date
School City and State	
[ ] ***SUBMIT THIS FORM WITH INSTITUTION CERTIFICATION FOR CURRENT ENROLLMENT***	

I hereby request continuation of coverage in the University Employee Health Care Plan for my child named above, who is or will be age 26 or older. I hereby acknowledge and certify:

- The student is enrolled on a full-time basis in an accredited university, college or vocational school and must remain enrolled on a full-time basis to remain eligible for coverage. I understand that my child may miss one semester or term per academic school year, as long as they are enrolled full-time in the other semesters/terms.
- The student is unmarried and must remain unmarried to continue eligibility for coverage in the plan.
- I provide at least 50% of the student's support and must continue to provide at least 50% of the student's support to remain eligible for coverage in the plan.
- The student will cease to be eligible for coverage at 12:01 a.m. on his/her graduation date, the last day the student attends classes, or if a change of status occurs wherein the student fails to meet any of the above conditions (e.g., marriage or no longer dependent on me for support).
- I must notify University Human Resource Management if the student no longer meets the eligibility requirements set forth above. Under such circumstances, the student may be eligible for continuation of coverage through COBRA if UHRM is notified of the change in status within **60 days** of the date the student is no longer eligible.
- I must certify the student's continued eligibility (and provide a certification from the institution) annually. However, if the student fails to meet the eligibility requirements at an earlier date, I acknowledge the student's coverage will end when he/she loses eligibility.
- I will be responsible for the full cost of any claims paid by the plan after the date the student loses eligibility under the plan.
- Any person who knowingly files a form containing any misrepresentation or any false, incomplete, or misleading information may be subject to discipline up to and including termination of employment and cancellation of coverage, and may be guilty of a criminal act punishable under law and subject to civil penalties.

Employee Signature: ______________________________ **Date:** ____________________

Return this completed form to:

University Human Resource Management ~ 250 E. 200 S., Suite 125, Salt Lake City, UT 84111
Phone: (801) 581-7447 / Fax: (801) 585-7375

Benefit Dept. Use Only	**Entry Date:**	**Entered By:**	**QC By:**	**QC Date:**