

DEPENDENT STUDENT STATEMENT

Group number: _____

Employee's name: _____

Employee's SS#: _____

Please complete the following information and forward to college/university:

A. I certify that _____ is _____ years of age, is unmarried, and dependent upon me for support. He/She is now a full-time student, as defined in the health plan, in an institution of higher learning, namely:

Institution: _____ Registrar's Phone#: _____

Signature of Employee _____ Date: _____

B. As a student I authorize the said institution to release any information regarding enrollment.

Signature of Student _____ Date: _____

Social Security #: _____

C. To be completed by college/university:

Please complete for the above named student and return to address below:

The above student is enrolled as a full-time student for (circle one) **spring/fall** of 20____ to 20____. Number of semester hours attended: _____.

Signature _____ Title _____ Date _____

Please mail to:

**Boon-Chapman Benefit Administrators
P.O. Box 9201
Austin, Texas 78766**

