**CERTIFICATE OF STUDENT STATUS**

**For: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I certify that I am the above named person’s parent or legal guardian, and I hereby certify that he/she meets the following criteria to be eligible as a dependent under my group health plan –

* is my spouse’s or my unmarried child
* is my dependent, as defined by the U.S. Internal Revenue Service
* is between 19 and 25 years of age (My employer might require a different age range.)
* is a full-time student at an accredited educational institution, enrolled during the following school term(s):

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| (Year) | (Month/Year) |  | (Month/Year) |  | (Number) |
| \_\_\_\_\_\_ FALL Term | \_\_\_\_\_\_\_\_\_\_ | to | \_\_\_\_\_\_\_\_\_\_ | for | \_\_\_\_\_\_ credits |
| \_\_\_\_\_\_ SPRING Term | \_\_\_\_\_\_\_\_\_\_ | to | \_\_\_\_\_\_\_\_\_\_ | for | \_\_\_\_\_\_ credits |
| \_\_\_\_\_\_ SUMMER Term | \_\_\_\_\_\_\_\_\_\_ | to | \_\_\_\_\_\_\_\_\_\_ | for | \_\_\_\_\_\_ credits |
| \_\_\_\_\_\_ Other: | \_\_\_\_\_\_\_\_\_\_ | to | \_\_\_\_\_\_\_\_\_\_ | for | \_\_\_\_\_\_ credits |

At (name and address of school): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The number of credits that constitutes full-time for this school is: \_\_\_\_\_\_

I will notify my employer and Hometown Health **immediately** if (student name) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** no longer meets anyone of the above-listed criteria as a dependent under my group health plan. I understand that failure to submit acceptable proof of student status eligibility when requested by Hometown Health may require that I reimburse Hometown Health for all benefits paid by Hometown Health for services incurred beginning on the first day of the month when (student name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ceases to quality as a dependent under my group health plan.

Hometown Health Group Plan Subscriber: (Your name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your signature (**must be notarized**): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscribed and sworn to before me on this \_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please return completed and notarized form to address below or fax to 775-982-3749:

**Hometown Health**

**Attn: Enrollment**

**10315 Professional Circle**

**Reno, NV 89521**

For questions, please contact Customer Service at 775-982-3232 or toll free at 800-336-0123.

If you have impaired hearing, dial our TTY/TDD number at 775-982-3240.