

FULL TIME STUDENT STATUS

Employee's Name	
Soc Sec #	
Dependent's Name	

Benefits are not available unless your dependent is a full-time student. Accordingly, we must obtain certain information regarding current student status.

PLEASE ANSWER THE FOLLOWING QUESTIONS AND RETURN IMMEDIATELY:

1. Is the above named claimant a full-time student? ____ Yes ____ No
If YES, please provide the following:

A. SCHOOL NAME AND ADDRESS:

- B. If NO, is the above named dependent on a leave of absence from a postsecondary educational institution for a medically necessary reason related to a serious illness or injury that began while the dependent was a full time student? ____Yes ____No

If Yes, we will send you a letter requesting additional information that may allow your dependent to continue coverage under your plan as specified in the federal legislation known as "Michelle's Law".

- C. Last day of current enrollment in school: ____/____/____

- D. Present class level: ___ FRESHMAN ___ SOPH ___ JR ___ SR

- E. Marital status: ___ SINGLE ___ MARRIED

- F. Is dependent covered by any other group insurance plan? ___ YES ___ NO

If YES, name of insurance carrier _____

- F. I certify that the above information is correct to the best of my knowledge.

Signature _____ Date ____/____/____

Please mail or fax to:
BGCWA Insurance Trust
100 Court Ave, STE. 306
Des Moines, IA 50309
800-245-8813(phone) 515-244-8650(fax)