



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 _____	_____	credits
_____	SPRING Term	_____	to _____	_____	credits
_____	SUMMER Term	_____	to _____	_____	credits
_____	Other:	_____	to _____	_____	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 any one the above-listed criteria to qualify 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 qualify as a dependent under my group health plan.

Hometown Health Group Plan Subscriber: (Your Name) _____

 (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
830 Harvard Way
Reno, NV 89502

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.