



STUDENT CERTIFICATION FORM

Please return to MVP Health Care, Attn: Enrollment Department

Subscriber Name: _____ Health Plan ID#: _____

Address: _____

Employer: _____ Group #: _____

Dependent's Name: _____ Birth Date: _____

Dependent's SSN: _____

PLEASE CHECK ALL THAT APPLY BELOW. Your student must meet one of these requirements to be eligible for continued coverage.

_____ My dependent is a full time student and not eligible for coverage through his/her own employer.

College/University: _____ Location: _____

School Year: _____ Expected date of graduation: _____

Freshman _____ Sophomore _____ Junior _____ Senior _____ Graduate _____

_____ My dependent is on an approved medical leave of absence from the above college.

Date leave of absence began: _____

Is your dependent employed?: _____ Yes _____ No

If yes, name of employer: _____

I UNDERSTAND THAT ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON, FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERTO, COMMITS A FRADULENT INSURANCE ACT. THIS IS A CRIME AND THE PERSON SHALL BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED \$5,000 AND THE STATE VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

Subscriber's Signature: _____

Date: _____