Student Coverage Questionnaire

Empire BlueCross BlueShield

MEMBER INFORMATION

Member's identification number

DEPENDENT'S INFORMATION

Last name	First name	MI	Date of birth

Relationship to member	Is dependent	Is dependent employed
	☐ Single ☐ Married ☐ Divorced ☐ Separated	☐ Yes ☐ Full-time ☐ Part-time ☐ No

List any other group insurance or pre-payment program the dependent is covered under

DEPENDENT'S SCHOOL INFORMATION

Is the dependent a full-time student? ☐ Yes ☐ No	School name
Type of school (college, trade, etc.)	School address
Expected date of Graduation	Expected date of full-time Course Completion?

Was the dependent a full-time student at an accredited school who is now on a leave of absence from the school due to illness or injury?
☐ Yes ☐ No

If yes, what is the name of the school attended prior to the medical leave?	What is the date the medical leave began?

(You must also attach a letter from the student's doctor which documents his/her illness or injury and certifies to the medical necessity of the leave of absence from the school)

I HEREBY CERTIFY THAT THE ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE

Signature of subscriber	Date

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 thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

WHEN FORM IS COMPLETE

Please fax completed forms to: 1-800-780-1224
OR
Mail to: Empire BlueCross BlueShield
P.O. Box 1407
Church Street Station
New York, NY 10008-1407