Fallsburg Teachers Association Trust

1387 Fairport Road, Building 1000, Suite A1

Fairport, NY 14450

Student Coverage Questionnaire

Member's name:_____ Social Security #_____

Dependent's name:_____ Dependent's Date of Birth:_____

Relationship to member:_____

Is dependent? ☐ Single ☐ Married ☐ Divorced ☐ Separated

Is dependent employed? ☐ Yes- Full-Time ☐ Yes-Part-Time ☐ No

List of other group insurance or pre-payment program that the dependent is covered under:

_____

Is dependent a student? ☐ Yes- Full-Time ☐ Yes-Part-Time ☐ No

School name and address:_____

Type of school (college, trade, etc.)_____

Expected date of: Graduation_____ 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 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 member 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.