

STUDENT STATUS VERIFICATION

GROUP NAME:

EMPLOYEE:

DEPENDENT:

SEMESTER: FALL SPRING SUMMER YEAR: _____

SCHOOL:

CITY/STATE:

Although we verify student status twice yearly, this does not relieve you of the responsibility to notify your employer if your dependent is no longer in school and no longer eligible for coverage. Please contact Enrollment Services at 1-800-877-1122 with any questions regarding this form.

The dependent listed above is dependent on me for support, and enrolled as a full time student.

I understand that a change in student status could terminate coverage under my health benefit plan and the Plan is not responsible for any costs or expenses, and I further agree to reimburse the Plan for any such costs or expenses which may be paid by the Plan when my dependent was not under student status.

(Employee Signature)

(Date)

Not valid without the employee's signature

This form can be faxed to 406-523-3187 or mailed to:
Allegiance Benefit Plan Management
Enrollment Department
PO Box 3018
Missoula, MT 59806