

INSURANCE DESIGN ADMINISTRATORS
169 Ramapo Valley Road, P.O. Box 470, Oakland, NJ 07436

EMPLOYER/GROUP NAME _____

EMPLOYEE NAME _____ **SS#** _____

STUDENT VERIFICATION INFORMATION

In order to enroll or update our records for your student aged dependent we will need to receive verification of full-time student status. If your dependent's effective date with this Plan is between January 1 and August 31, please submit verification for the Spring semester. If your dependent's effective date with this Plan is between September 1 and December 31, please submit verification for the Fall semester.

If your child is not a full-time student and is therefore not eligible to be covered under this Plan, he or she may still be eligible to continue coverage. Contact your Employer's Benefits Administrator for more information.

Please arrange to have the student verification information submitted at the time of enrollment, or as requested per semester, sent to the following address:

Insurance Design Administrators
P.O. Box 470
Oakland, NJ 07436
Attention: Enrollment Department

Thank you for your assistance.

If you have any questions, please call the IDA Enrollment Department at 1-800-225-1345.

Sincerely,

Enrollment Department
Insurance Design Administrators

TO BE COMPLETED BY AN ACCREDITED EDUCATIONAL INSTITUTION

NAME OF SCHOOL

ADDRESS

NAME OF STUDENT

SS#

PHONE

Is registered as a ___ full-time ___ part-time student for the _____ 20__ semester
which begins on _____ 20__ and ends on _____ 20__.

REGISTRAR'S SIGNATURE

SCHOOL SEAL

DATE