KAISER PERMANENTE®

# Student Certification

**Requirements for dependent student coverage:**

- Full-time student in an accredited institution
- Dependent upon subscriber for support
- Unmarried
- Under ____ years of age

Dependent's name | Dependent's Medical Record Number

Birth date | Dependent's Social Security number

School name

School address | City, state, zip

Student ID number | Number of units carried

Subscriber's name | Subscriber's Medical Record Number

Purchaser ID

I certify that the dependent shown above meets all of the requirements for coverage on my account as a full-time student. I understand the Health Plan coverage for this dependent will terminate on the first day of the month following the date that any one of these requirements is no longer met.

X
Subscriber's signature

Social Security number | Date

Employee: Return to Employer

Employer: If Kaiser Permanente certifies your students, return this form to your membership document address.

09/00

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