MEMBER REQUEST

STUDENT CERTIFICATION AFFIDAVIT

I hereby certify that _____ _____
(Student Name) (Social Security Number)

_____ is a full time student at _____
(Date of Birth) (Accredited Educational Institution)

_____ _____ _____
(Registrar Office Phone Number) (City/Town/State) (Zip Code)

Date the semester begins _____/_____/_____

I hereby certify that information provided above is true and accurate. I further agree to inform Blue Cross Blue Shield of Massachusetts immediately of any changes in this information. I authorize Blue Cross Blue Shield of Massachusetts to confirm the information I have provided with the registrar of the educational institution identified and to use this information to determine whether the individual I identified as a student above is in fact eligible for dependent student health coverage. I further authorize the educational institution identified above to release information to Blue Cross Blue Shield of Massachusetts in order to verify student status and determine eligibility for coverage. If I misrepresent or provide false or incomplete information, my membership may be terminated (including retroactively) at the discretion of Blue Cross Blue Shield of Massachusetts and/or my employer.

I understand that this affidavit must be signed by the **policy holder** and received by Blue Cross Blue Shield of Massachusetts before any coverage can become effective for my dependent.

Date _____/_____/_____

Policy Holder Information

Print Name: _____ _____
(Policy Holder Signature)

Address: _____

_____ _____
(BCBS of MA Identification Number)

Phone: _____ _____
(Employer Name)

<u>Fax To</u>: 1-866-748-5500

OR

<u>Return To</u>:
Enrollment Operations
PO Box 9145
N. Quincy, MA 02171