Health and Dental Plan
Student Certification Form

Your family membership provides coverage for full-time students between the ages of 19 and 25. Please complete the following information so that your dependent will continue to be covered while he or she is a student.

Student's Name: ____

Student's Social Security Number: ____________________________________

Student's Date of Birth: ____

Current School Year Enrollment Date: _________________________________

Name of School: ____

Subscriber's Name: ____

Subscriber's Employee ID: ____

Health Plan: ____

Dental Plan: ____

_______________________________________ ______________

Subscriber's Signature Date

Please have this form stamped by the school's Registrar's Office.

______________________________________ is enrolled as a full-time student.

____

School Certification (Stamp)

2/2008

Return Address: Boston University
Human Resources
Benefits Section
25 Buick Street
Boston, MA 02215