



# Verification Form Unmarried Dependent

## SECTION II (PLEASE PRINT)

SUBSCRIBER'S NAME		GROUP NO.	IDENTIFICATION NO.
SUBSCRIBER'S SOCIAL SECURITY NO.	DEPENDENT'S NAME		DEPENDENT'S BIRTHDATE

Your contract provides for continuation of coverage for dependent to age \_\_\_\_\_ if he / she is unmarried, and dependent on you for over half of his or her support.

If your child qualifies under the above provisions, complete this form and return it to Blue Cross immediately to have your child continued on your contract for another year.

I certify that my above named child is unmarried, is dependent on me for more than one-half support (as defined in regulation of the Internal Revenue Service).

PARENT'S SIGNATURE

DATE SIGNED

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PLEASE READ THE FOLLOWING INFORMATION CAREFULLY  
Your dependent \_\_\_\_\_ is being removed from your contract effective \_\_\_\_\_

Our records indicate that your contract provides the dependency coverage checked below:

Dependent is removed from the parent's Agreement(s) at the end of the agreement year following 19th birthdate. (For information on our individual coverage programs, return the enclosed postage-paid card.)

Dependent is eligible to continue on parents contract to age \_\_\_\_\_ if he or she is an unmarried student registered in a secondary school, college or university. (Complete SECTION I of the attached VERIFICATION FORM.)

Dependent is eligible to continue on parents contract to age \_\_\_\_\_ if he or she is unmarried. (Complete SECTION II of the attached VERIFICATION FORM.)

(OVER)

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY

The basic group contract provides coverage for unmarried dependent children to the end of the agreement year following their 19th birthday.

Some special group agreements extend coverage for dependents beyond age 19 under certain conditions.

On the reverse side of this form, we have indicated the dependency coverage provided under your contract.

**NOTE:** If your child is incapable of self support because of mental or physical incapacity, is dependent on you for over half of his/her support and your child's disability commenced prior to attaining 19 years of age, please contact us for an application to continue as a handicapped dependent. If all of the requirements are met, your child will be continued on your contract.

(OVER)



## Verification Form

1901 Market Street  
Philadelphia, Pennsylvania  
19103-1480

### SECTION I (PLEASE PRINT)

### Unmarried Student Dependent

SUBSCRIBER'S NAME		GROUP NO.	IDENTIFICATION NO.
SUBSCRIBER'S SOCIAL SECURITY NO.	DEPENDENT'S NAME		DEPENDENT'S BIRTHDATE

Your contract provides for continuation of coverage for dependent to age \_\_\_\_\_ if he / she is unmarried, (2) a registered student in regular fulltime attendance in a secondary school, college or university and (3) is dependent on you for over half of his or her support.

If your child qualifies under the above provisions, complete this form and return it to Blue Cross immediately to have your child continued on your contract for another year.

I certify that my above named child is unmarried, is dependent on me for more than one-half support (as defined in regulation of the Internal Revenue Service) and is a registered student in regular full-time attendance at

NAME OF SECONDARY SCHOOL, COLLEGE OR UNIVERSITY

PARENT'S SIGNATURE

DATE SIGNED