



Please indicate the health and/or dental plan(s) in which you participate:

CareFirst Traditional CareFirst Preferred Provider
CareFirst Blue Choice HMO PPO Dental PPO Premier Dental

Student Certification for Overage Dependent Medical & Dental Coverage

To Be Completed By Subscriber:

I certify that my son/daughter, _____, is unmarried, is financially dependent, and is a full-time student (12+ credit hours/semester) enrolled in an accredited school. His/her date of birth is _____. I understand that his/her protection under my coverage will terminate on the last day of the calendar month in which he/she marries, graduates, or ceases to be a full-time student.

Name of School: _____

Address of School: _____

Semester: Fall ___ Spring ___ Start date: (month) _____ (day) _____ (year) _____

End date: (month) _____ (day) _____ (year) _____

Expected graduation date is: (month) _____ (year) _____

Attached is a copy of his/her college schedule or a letter from the Registrar's Office, stating my child is attending school full-time, as required to keep my child on my healthcare. I understand if I do not provide such proof, my child will lose eligibility and cease as a dependent on my plan(s).

I understand that his/her protection under my coverage will terminate on the last day of the calendar month in which he/she ceases to be a full-time student as defined in the Certificate/Evidence of Coverage and that **I must notify the Benefits Office** once my child is no longer eligible as a dependent under my plan. I also understand that I must provide student verification **every** semester to keep my child on my healthcare as an eligible dependent.

Parent Name (Please Print)

Parent Signature (Subscriber)

Date

HCPS Employee ID # _____

***Please Note:** Student Schedule must contain College name, Student name and number of credits.

Submit this information to: **Harford County Public Schools**
Attention: Benefits Office
102 South Hickory Ave.
Bel Air, MD 21014