CNIC Health Solutions®
A Rocky Mountain Health Plans TPA

Return to: PO Box 76150; Colorado Springs, CO 80970-6150 Or Fax to: (303)749-1188

VERIFICATION OF FULL-TIME STUDENT STATUS

STUDENT/DEPENDENT NAME: GROUP #
EMPLOYEE NAME: EMPLOYEE ID#
ADDRESS:

To the Registrar of _____,
Name of School

I authorize release of the following information in order that I may obtain or continue medical coverage through my current group health plan.

_____ _____
Student ID # Date of Birth

_____ _____
Signature of Student Date

This dependent is not eligible for coverage without this information, which is required for each new semester.

1. Is this dependent enrolled and recorded as full-time student during this semester? _____ yes _____ no
2. Was he/she enrolled last semester? _____ yes _____ no
3. How many units are and were carried? This semester _____ Last Semester _____
4. How many units constitute a full time student at your institution? _____
5. This semester begins on _____ and will end on _____

School seal

_____ _____
Registrar Date