

DEPENDENT STUDENT STATEMENT

This form must be completed for persons requesting coverage for a dependent child under the Ancira Enterprises Employee Benefit Plan *Full Time Student provision, as outlined in the Plan Document.*

Group Name/ID#: Ancira Auto Group 7670-00-410069

Employee's Name: _____ SS#: _____

Employee:

- 1. Complete your section A below. Have your Dependent Child complete his/her section B.
- 2. Forward to the college/university administration office to complete section C.

A. I certify that the dependent named below is _____ years of age, is unmarried, and dependent upon me for financial support. S/he is now a full-time student (as defined in the health plan document) at the following institution:

 Name of Institution () _____
 Phone # to Registrar

Most recent tax year in which you claimed this dependent on your income taxes: _____

 Signature of Employee Date

B. As a student, I authorize the named institution to release any information regarding my enrollment to the Plan Administrator and its agents/assigns for the purpose of determining eligibility for insurability under the Plan and hereby release and hold harmless the institution and related parties for any result disclosing such information may cause.

Print FULL NAME
of STUDENT: _____

 First Middle Last

 Signature of Dependent/Student Date of Birth

 Social Security # Date

C. TO BE COMPLETED BY COLLEGE/UNIVERSITY:

Please provide the following information and mail this completed form to the address shown below.

The above student is enrolled as a full-time student for _____ to _____
(specify semester months and year)

Number of semester hours enrolled: _____

Certified by: _____
Signature Title Date

College/University Agent, please MAIL THIS COMPLETED FORM to:

ANCIRA Health Plan Student Certification, c/o Team Services, P. O. Box 29719, San Antonio, TX 78229