HealthComp
Third Party Administrators

PATIENT:	_____	GROUP NO:	_____
EMPLOYEE:	_____	ACCT NO:	_____
CLAIM NO:	_____	INCURRED:	_____
PROVIDER:	_____	CHARGE:$	_____

RE: Full-Time Student Status

Dear Participant:

We have received a claim for the patient named above and are unable to complete the processing of this claim until we have received verification of continued eligibility under the Plan.

According to the eligibility provisions of your Group Health Coverage, all dependent children over the limiting age are required to show proof of Full-Time Student Status.

Please complete the statement below: sign, date and return this form with a copy of the current Class Schedule, including number of hours/units taken.

I certify the dependent listed above is _____ years of age and a Full-Time Student, enrolled in _____ hours/units for the (fall or spring) _____ semester of the year _____, at the following educational institution:

Name of Institution: _____
Address: _____
_____ Phone # _____

I certify that he/she is unmarried and dependent upon me for support and maintenance. I authorize the said institution to release any information regarding the enrollment status of my dependent child.

_____ _____
Signature of parent Date

The requested information must be received by HealthComp within forty-five (45) days from the date of this request, or the claim will be denied/closed.

Your dependent may also be eligible to retain coverage if they are on a medically necessary leave of absence from their learning institution. Please review your Plan Document or contact the Plan Administrator for further information.

If you have any questions, please contact our office at (800) 442-7247.

Sincerely,
HealthComp Administrators
Claims Department