



Date \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Identification Number \_\_\_\_\_

Group Number \_\_\_\_\_

STUDENT DEPENDENT INFORMATION REQUEST

Your coverage may provide continued dependent benefits under certain conditions after reaching the limiting age. Please provide the following information regarding your student dependent:

1. Dependent Name: \_\_\_\_\_

2. Relationship to Subscriber: \_\_\_\_\_

3. Dependent's Marital Status: \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced

If married or divorced, please indicate date of event: \_\_\_\_\_

4. Is this dependent presently a student? \_\_\_\_\_ Yes \_\_\_\_\_ No

a) If yes, indicate status: \_\_\_\_\_ Full Time \_\_\_\_\_ Part Time

Anticipated Graduation Date: \_\_\_\_\_

b) If no, date last attended on a full time basis: \_\_\_\_\_

5. Please list all dates of enrollment below:

Table with 3 columns: Name of School Attended/Attending, Enrollment Dates (indicate quarters or semesters), Type of School. It contains three empty rows for data entry.

Please use the reverse of this form to explain any lapses in attendance other than school vacations.

6. Authorization for Release of Information from the educational institution the dependent is attending.

I, \_\_\_\_\_, authorize the release of information to BCBSM for the purpose of continuing healthcare coverage under my parent's policy.

(Student Signature)

(Date)

To ensure timely review of your request, please return this completed form within 10 days to the address below.

Blue Cross and Blue Shield of Minnesota
P.O. Box 64560
St. Paul, MN 55164-0560