



**REASON CODES:**

- B. Dependent Reached Age 23/24/25
- C. Group Cancel - Open Enrollment
- D. Deceased
- G. Group Cancel - Mid-contract
- I. Transferring to Another Group
- L. Layoff
- M. Moved out of Area
- N. Nonpayment
- O. Member Cancel - Open Enrollment
- P. Personal Reasons
- R. Retired
- T. Terminated Employment
- U. Dependent Age Cut-off (age 19)
- V. Medicare
- W. Now Under Spouse's Plan
- X. No Longer Eligible
- Y. Dissatisfaction with the Plan
- Z. Dependent Age Cut-off - Waiver Required

**ELIGIBILITY FOR STUDENT COVERAGE**

(applies only to those members whose contract includes an age extension rider)

Your contract may require that a dependent age 19 or above maintain full-time student status (a minimum of 12 credit hours) at an accredited college or university to remain eligible as a dependent on your contract.

Please check the statement that best describes your child's student status:

**Yes, my child is a full-time college student** as defined above.

Following is information that may be verified:

Child \_\_\_\_\_ College or University \_\_\_\_\_ Student ID No. \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip Code \_\_\_\_\_ Expected Date of Graduation \_\_\_\_\_

Child \_\_\_\_\_ College or University \_\_\_\_\_ Student ID No. \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip Code \_\_\_\_\_ Expected Date of Graduation \_\_\_\_\_

*(Please attach separate sheet if you have additional children who are eligible full-time students)*

**Yes, my child is a full-time college student but is currently on medical leave.**

Please attach a note from your physician verifying your child's condition.

**No, my child is not a full-time college student.** Please send me information on a direct pay policy.

**PRIOR HEALTH INSURANCE (CONTINUED)**

HEALTH INSURANCE COMPANY (include address and phone number of previous carrier)	ID #	COVERAGE FROM MONTH/YEAR	COVERAGE TO MONTH/YEAR

**CERTIFICATION/ACKNOWLEDGEMENT**

I certify that the information given on this form is current to the best of my knowledge and I have read and agree to this acknowledgement. This Application CANNOT be processed if Birth date(s) and Social Security Number(s) are not completed. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact materials thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation.

I understand that this application and subsequent acceptance of services on behalf of myself, spouse and eligible dependent(s) listed are subject to the terms of the applicable contracts and riders issued by Independent Health, its affiliates or subsidiaries ("Independent Health"). I authorize my employer to deduct the necessary Health Services Fees, if any, from my wages or salary, with the understanding that he/she acts as my agent in all dealings with Independent Health, and that all acts performed by him/her and all notices given to him/her in such dealings are binding upon me, as not prohibited by statute or regulation. I understand that any person or institution who shall have rendered services to me or to any of my dependents under an Independent Health contract shall make available to Independent Health to such an extent as may be reasonable, any photographs, records, or information regarding such services, required by Independent Health, which shall be kept confidential by Independent Health unless disclosure is permitted by applicable law, regulation and/or contract.

I acknowledge that if I am presently without coverage for longer than sixty-three (63) days, then a pre-existing condition waiting period may apply. Pre-existing condition waiting periods apply to individuals with conditions diagnosed or recommended for treatment within six (6) months prior to the enrollment date of new coverage and shall not exceed twelve (12) months following this date.

Independent Health's Encompass and Encompass Elect are issued through Independent Health Association, Inc. Independent Health's Encompass Plus, Encompass Elect Plus and Select Plus are issued by Independent Health Benefits Corporation, an affiliate of Independent Health Association, Inc. Independent Health's Custom Coverage is administered by Independent Health Corporation, an affiliate of Independent Health Association, Inc.