



Community Name: _____

Subscriber ID# _____

STUDENT CERTIFICATION AFFIDAVIT

I hereby certify that _____,
 (Student Name) (Social Security Number)

_____ is a full-time student at
 (Date of Birth)

_____ (Accredited Educational Institution) _____ (Registrar Office's Phone Number)

_____ (City/Town) _____ (State) _____ (Zip)

Date the semester begins: ____/____/____

I hereby certify that the information provided above is true and accurate. I further agree to inform MIIA/Blue Cross and Blue Shield of Massachusetts, Inc., immediately of any changes in this information. I understand and agree that the above information will be used to determine whether my dependent is entitled to dependent student health care coverage. I understand that if I misrepresent or provide false or incomplete information in this Affidavit, the above named dependent will be removed from my coverage, and my membership may, itself, be terminated (including retroactively) at the discretion of MIIA/Blue Cross and Blue Shield of Massachusetts, Inc., and/or my employer. I also understand that MIIA/Blue Cross and Blue Shield of Massachusetts, Inc. may retract claim payments (including retroactively).

I understand that this signed affidavit must be received by MIIA to maintain coverage for my dependent.

AUTHORIZATION

I authorize the registrar's office at the above-named educational institution to provide MIIA and/or Blue Cross and Blue Shield of Massachusetts, Inc. with any and all information necessary to confirm the above-named student's status as a full time student at the above educational institution, such information to include the number of credit hours he/she is enrolled in per semester.

Date: ____/____/____

 (Subscriber's Signature)

 (Print Subscriber's Full Name)

PLEASE RETURN THIS FORM TO:
MIIA Health Benefits Trust
One Winthrop Square
Boston, MA 02110
or Fax to: 617-542-6513