

6740 North High Street  
Worthington, Ohio 43085-2512

# Anthem

## Student Certification

Date: (m/d/y) \_\_\_\_\_  
Group #: 003320130  
Contract/Member ID: \_\_\_\_\_  
(Available on your ID card)

**Student Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

Your contract provides benefit administration for unmarried dependent children ages 19 - 25 as long as they are attending school on a full-time basis. Please verify your child's eligibility for benefits under your contract. **Please answer the following questions and promptly return this form to Anthem Blue Cross and Blue Shield.**

1. Dependent's relationship to contract holder? \_\_\_\_\_
2. Is the dependent's legal residence the same as the contract holder? \_\_\_\_\_  
If no, explain: \_\_\_\_\_
3. Marital status of dependent: \_\_\_\_\_  
If married, the date of marriage: \_\_\_\_\_
4. Is the dependent covered under other insurance? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, what is the name of the carrier and member's identification numbers?  
\_\_\_\_\_  
Effective date of other insurance: \_\_\_\_\_
5. Is the dependent a full-time student? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, name of school: \_\_\_\_\_  
Month and year last attended: \_\_\_\_\_  
Total hours attended per quarter/semester: \_\_\_\_\_
6. Is the dependent mentally or physically disabled? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, at what age? \_\_\_\_\_

**This questionnaire must be returned within 30 days to ensure continuous coverage for the above identified dependent. Please return your completed questionnaire to:**

**ANTHEM BLUE CROSS AND BLUE SHIELD**  
**ATTN: National Enrollment WNB-740**  
**6740 N. High Street**  
**Worthington, OH 43085**

I hereby certify that the above information is correct to the best of my knowledge and authorize release of any information with respect to this recertification.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_