



BlueCross BlueShield of Minnesota

An independent licensee of the Blue Cross and Blue Shield Association

Date _____

UST Department of Human Resources

Identification Number _____

Mail # AQU 217

2115 Summit Avenue

Group Number _____

St. Paul, MN 55105

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:

| Name of School Attended/Attending | Enrollment Dates (indicate quarters or semesters) | Type of School |
|-----------------------------------|--|----------------|
| | | |
| | | |
| | | |

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

6. Social Security number of this dependent: _____

(Subscriber Signature)

(Date)

7. 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.

X14927R01 (2/02)

Please mail form to AQU217 or Fax to 651-962-6524