



**IMPORTANT NOTICE  
STUDENT STATUS VERIFICATION**

Name: \_\_\_\_\_ Group Number: \_\_\_\_\_  
*Employee Name*

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

RE: \_\_\_\_\_  
*Dependent Name* *Employee's Subscriber ID (W99-99-9999)*

Our records show that you have a dependent, named above, who is, or will soon be, between the ages of 19 to 24 years. To determine this dependent's continuing eligibility, you will need to complete and sign this letter.

\_\_\_\_\_ The dependent listed above is not a full-time student. (This dependent will lose eligibility for coverage, which may reduce the cost of coverage; this dependent may also have benefit continuation rights – please refer to your Summary Plan Description).

\_\_\_\_\_ The dependent listed above is currently a full-time student (or on summer/school holiday), at a school that meets the requirements, outlined in your Summary Plan Description. In addition, this dependent must be unmarried and you must be claiming this dependent on your taxes.

Please complete the following:

Name of School: \_\_\_\_\_

Address of School: \_\_\_\_\_

School's Telephone Number: \_\_\_\_\_

Dependent's Social Security number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

This verification pertains to the following semester:  Fall 200\_\_\_\_ Semester  Spring 200\_\_\_\_ Semester

If your dependent resides out-of-state, please provide their out-of-state address.

\_\_\_\_\_  
(Street Address) (City) (State) (Zip Code)

Your signature below will allow the Plan to verify your dependent's enrollment, if necessary, and allow the Plan to seek reimbursement for claims paid, from you, if your dependent does not qualify as a full-time student. If we do not receive this Full-Time Student verification letter within 30 days prior to the commencement of the Fall (September 1<sup>st</sup>)/Spring (February 1<sup>st</sup>), semester, you will receive a mandated COBRA election notice.

By signing this form, I assert that the information furnished is true and correct. I understand that failure to return the form to the address/fax below before the commencement of the spring/fall semester may result in the termination of coverage for the dependant named above.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

If you have any questions please contact Pinnacle Customer Service (P) 800.649.9121. The completed form can be faxed to (F) 949.809.8955 or e-mailed to AdminElig@pinnacletpa.com.

Sincerely,  
Administration Department