PINNACLE
CLAIMS MANAGEMENT, INC.
Innovation through Technology

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 and (please refer to your Summary Plan Description for maximum allowable age). 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 1st)/Spring (February 1st), 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, need a specific fax number to send this to or require further assistance, please contact your Administration Specialist or our Customer Service Department at 800-649-9121.

Sincerely,
Happy Nichols, Manager of Administration Eligibility

Rev 11/2005