STUDENT VERIFICATION FORM

The DGA-Producer Health Plan provides coverage for eligible unmarried children from their 19th birthday to their 23rd birthday, provided they are dependent upon the Participant for full support and are a full-time student at an accredited school.

Sections 1 and 2 of this form must be filled out in their entirety and returned to the Health Plan office by fax to (323) 866-2399 or by mail to the address at the bottom of this form.

SECTION 1 (TO BE COMPLETED BY THE PARTICIPANT)

Participant Name: ____________________

SSN or Health Plan ID Number: ____________________

Name of Dependent/Student: ____________________

Dependent's Date of Birth: ____________________

Relationship to Participant: ____________________

Expected Date of Graduation: ____________________

If the Health Plan office is not notified in writing within 60 days after your dependent child ceases to be a full-time student, your dependent child will forfeit the right to elect COBRA continuation coverage.

I certify that the above-named unmarried child is dependent upon me for full support and that the above information is correct.

Participant's Signature: X ____________________ Date: __________

SECTION 2 (TO BE COMPLETED BY THE SCHOOL'S ADMISSIONS DEPARTMENT)

Name of School: ____________________

Address of School: ____________________

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Phone Number: ____________________

Current Semester/Quarter: From: __________ To: __________

Number of Enrolled Units: __________ Is Student Considered Full-Time: ☐ Yes ☐ No

Signature of Registrar or School Seal/Stamp: X ____________________ Date: __________