DAKOTACARE®

ER 6 (DT 195)

DEPENDENT ELIGIBILITY/STUDENT VERIFICATION FORM

Dependent's Name: _____
(Last Name) (First Name)

Member ID Number: _____

Social Security Number: _____ Date of Birth: _____

Failure to accurately complete and return this form to DAKOTACARE will result in claim denial as well as termination of dependent coverage.

PLEASE CHECK ONE OF THE FOLLOWING:

A. ( ) Totally disabled as of: _____
(Date of Onset)

B. ( ) Ineligible due to:

1) No longer Full-time student as of: _____
Date

2) Married on: _____
Date

3) Employed full-time on: _____
Date

4) In Military service as of: _____
Date

5) Not dependent on subscriber for support and maintenance as defined by the Internal Revenue Code as of: _____
Date

C. ( ) Full-time student on medically necessary leave of absence as of: _____
Date

D. ( ) Full-time student (Complete information below)
Name of Educational Institution: _____
City/State where institution is located: _____
Signed: _____ Date: _____
Member's Signature

NOTE: It is your responsibility to notify DAKOTACARE in the event that the status of the above dependent changes for any reason.

Class schedules are not acceptable forms of verification.

The Current Enrollment Verification Certificate from the National Student Clearinghouse may be provided as verification and does not need to be accompanied with a registrar's signature or school seal.

MUST BE COMPLETED BY REGISTRAR:

School Term: Fall: _____ From: _____ To: _____
Student Classification: Full-time: _____ Part-time: _____
School Term: Spring: _____ From: _____ To: _____
Student Classification: Full-time: _____ Part-time: _____
Expected Date of Graduation: _____

I hereby certify that the above information is true and correct to the best of my knowledge:

_____ _____
Date School Registrar Signature

(SCHOOL SEAL REQUIRED)

Return to: **DAKOTACARE**
2600 West 49th Street
Sioux Falls, SD 57105-6575