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International Medical Group®
P.O. Box 88509
Indianapolis, IN 46208-0509 USA

DEPENDENT STUDENT CERTIFICATION

Group Name _____ Group# _____
Insured's Name _____ Identification # _____
Insured's Address _____

I certify that _____, my son/daughter who is _____ years of age, is enrolled and a full-time student in an institution of higher learning.

Dates of enrollment: From _____ to _____
month/day/year month/day/year

Institution: _____
Address of registration office: _____
_____
Telephone # of registration office: _____
Student's Social Security, Passport, or License Number:_____

I certify that he/she is unmarried and is dependent upon me for support.
I authorize the said institution to release any information regarding the enrollment status of my son/daughter.

_____
Signature of Parent/ Date

_____
Registrar Office/ Admissions Office Date (Seal)

This form is for verification of Enrollment Eligibility. International Medical Group, at its discretion, may require additional documentation, such as grade transcripts or a letter from the educational institution at the time of claim.