

## Confirmation of Student Status for Dependent Children Bermuda Life Insurance Company Limited

A. Name of Employer						
Employer Name						Group/Account Number
B. Employee Statement						
Last Name		First Name		Middle Initial		Date of Birth (MM/DD/YY)
Work Phone	Home Phone	Cell Phone		Email		
C. Dependent Coverage - For Group Health Insurance Only						
full-time attendance at a recognised school, college or university, dependent upon the employee for financial support, reside with and form part of the employee's household, unless temporarily absent to attend a recognised educational institution abroad, and be registered as a dependent in the records of the employer.  To ensure continuous coverage we require updated information annually. Coverage may be continued under the following circumstances:  • for mentally or physically disabled children over age 19 who are incapable of self support subject to proof of disability  • for a 12 month Gap Year Extension for dependent children between ages 19-26 who are unemployed, were previously and now are not full-time students, and who otherwise satisfy all other conditions of dependent coverage described above. Only one 12 month period of coverage is allowed.						
Child's Last Name		First Name		Middle Initial		Date of Birth (MM/DD/YY)
D. School Information						
Is the above child:  • currently a full-time student as defined above?  • enroled in a recognised school, college or university for the next semester or, coverage to continue for 12 months under the Gap Year Extension?  • if a Gap Year Extension applies, please provide date of graduation						
Name of School, College or University				Address		
E. Special Section						
Any person, who with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits a declaration or files a claim containing a false or deceptive statement, is guilty of insurance fraud.						
F. Declaration						
I certify that the statements on this form are true and complete to the best of my knowledge and belief, and that no material information has been withheld or suppressed.  I understand that claims are eligible for payment only if the above-named child satisfies the conditions of dependent coverage described above on the date that care, treatment or services are provided.						
Employee Signature D					Date (MM/I	DD/YY)

Please Return the Completed Form Directly to Your Human Resources Department or directly to Group Insurance Administration at the Argus Group