

## DEPENDENT STUDENT CERTIFICATION

Please provide the following information concerning your dependent 19 years or older:

|  |  |  |
|--|--|--|
| <b>ENROLLEE INFORMATION/TO BE COMPLETED BY ENROLLEE</b>  |  |  |
| Employer:  |  |  |
| Enrollee's Name:   |  |  |
| Enrollee's Social Security #:  |  |  |
| Dependent's Name:  |  |  |
| Dependent's Birthdate:   |  |  |
| Dependent's Social Security #:   |  |  |
| Is Dependent Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No                                |  |  |
| Is Dependent Covered Under Any Other Group Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |

*The following information is to be completed by the Registrar's Office of the college your dependent is attending. Failure to have this form completed will result in a delay of coverage for your dependent.*

|   |  |
|---|--|
| <b>SCHOOL INFORMATION/TO BE COMPLETED BY SCHOOL REGISTRAR</b>           |  |
| Name, address and phone number of school dependent is enrolled in:      |  |
|   |  |
| Is dependent enrolled and attending classes as a full-time student?     |  |
| If no, explain:   |  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No                |  |
| Dates of: A. Current School Enrollment: From ___/___/___ To ___/___/___ |  |
| B. Graduation (expected): _____   |  |

\_\_\_\_\_  
Registrar's Stamp

\_\_\_\_\_  
School Contact Person (please print)

\_\_\_\_\_  
Date

Please return this form to:

GAIL READ  
BREWSTER CENTRAL SCHOOL DISTRICT  
30 FARM TO MARKET ROAD  
BREWSTER, NY 10509