



# Confirmation of Full-Time Student Status

for Health Benefits Eligibility

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**UnitedHealthcare**  
**Attn.: Enrollment Department**  
P.O. Box 931  
Frederick, MD 21705-0931

## Corporate Headquarters

To Contact Member Services for:

MD-Individual Practice Association, Inc. (M.D. IPA),  
Optimum Choice, Inc. (OCI), and  
MAMSI Life and Health Insurance Company (MLH)

4 Taft Court  
Rockville, MD 20850

301-360-8115 or 1-800-709-7604

Visit our Web site, [www.mamsiUnitedhealthcare.com](http://www.mamsiUnitedhealthcare.com).



# Confirmation of Full-Time Student Status for Health Benefits Eligibility

Please complete the top portion of this form and have the Registrar of your son's/daughter's school complete the bottom half and return to UnitedHealthcare for processing. If you have any questions regarding this form, please contact our Member Services Department (see reverse side).

Please indicate the health plan with which you participate:

M.D. IPA<sup>SM</sup>  
A UnitedHealthcare<sup>®</sup> Company

MAMSI<sup>®</sup> Life and Health Insurance Company  
A UnitedHealthcare<sup>®</sup> Company

OPTIMUM CHOICE, INC.<sup>SM</sup>  
A UnitedHealthcare<sup>®</sup> Company

## To Be Completed By Subscriber

I hereby certify that my son/daughter, \_\_\_\_\_, is unmarried, maintains legal residence in the Service Area\* and is a full-time student (12+ credit hours/semester) enrolled in an accredited school. His/her date of birth is \_\_\_\_\_. I understand that his/her protection under my coverage will terminate on the last day of the calendar month in which he/she marries, ceases to maintain legal residence in the Service Area\*, graduates or ceases to be a full-time student.  My son/daughter will not be returning to school.

\_\_\_\_\_  
Son's/Daughter's Social Security Number      Subscriber's Member Number      Subscriber's Signature      /      Date

## To Be Completed By The Registrar

Please complete the following information on the above-named student.

Name of School: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

At the beginning of the fall semester, the enrolled full-time student will be required to provide verification of attendance, including the beginning and ending dates of the school attended. If this information is being requested between January 1 and July 31, please provide verification of attendance for the spring semester. Expected length of attendance this semester is:

(Month) \_\_\_\_\_ (Year) \_\_\_\_\_ TO (Month) \_\_\_\_\_ (Year) \_\_\_\_\_

If the above student has been continuously enrolled as a student at your institution, has he/she been a full-time student?

Yes       No      If no, please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Please affix school seal here.

Verified by \_\_\_\_\_

\_\_\_\_\_  
Title      /      Date

Thank you for your assistance.

\*Applicable to HMO members only.