CaliforniaChoice®
Your Health. Your Choice.®

Full-Time Student Verification

For Medical and Dental Enrollees

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www.calchoice.com

If you wish to include a dependent between the ages of 19-24 under your medical and/or dental coverage, your dependent must meet the following eligibility requirements:

- Unmarried or not involved in a domestic partnership
- Financially dependent upon the Employee per IRS guidelines
- Enrolled as a full-time student (minimum 12 units) in a qualified college, university, vocational, or secondary school.

Please note: A dependent child enrolled as a full-time student will not lose coverage because of a break in the school calendar or because he or she takes a medical leave of absence from school, for up to 12 months or until the date on which the coverage is scheduled to terminate under the terms and conditions of the plan, whichever comes first. ***Physician Certification*** *will be required and must be submitted 30 days prior to the medical leave from school if the leave is foreseeable. If the leave is not foreseeable, the request must be submitted within 30 days of the medical leave from school.*

This form must be completed and signed by the employee. Failure to complete and submit this verification may result in the denial of services/claims for the dependent.

Employee Last Name

Employee First Name

Employee Social Security Number

Student's Name ______________________ Date of Birth ______________

School Name ______________________

School Address ______________________

I hereby certify that the above dependent is currently enrolled as a full-time student at the school listed above. I also understand that California*Choice*® reserves the right to contact the school for verification of this information.

Employee Signature:	**Date:**

Physician Certification

The above student is under my care for a condition that requires a medical leave of absence from school.

Begin Date ______________________ End Date ______________________

Medical Necessity ______________________ ICD9 Code ______________________

Physician Name ______________________ Telephone Number ______________________

Physician Signature:	**Date:**

Employer/California*Choice* Use Only	Group #

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