VERIFICATION OF FULL TIME STUDENT STATUS

State Form 50674 (R3 / 10-07)
INDIANA STATE PERSONNEL DEPARTMENT

Dependents on the State of Indiana Health, Dental, Vision, and Life plans are eligible for coverage until the end of the calendar year of their 19th birthday.

Coverage may extend beyond the limiting age if the dependent is a full-time student at an educational institution. Full-time students may be covered until the end of the calendar year of the 23rd birthday.

You must complete this form to enroll each of your dependents if the above condition applies. Return this form to the person in your agency responsible for benefits administration. Do not send this form directly to the insurance companies. Please print clearly.

Name of employee ______________________________

Employee ID: 10000☐☐☐☐☐☐

Name of dependent ______________________________ Dependent DOB ☐☐-☐☐-☐☐

Dates enrolled full-time:

Beginning Date ☐☐-☐☐-☐☐ Anticipated Ending Date ☐☐-☐☐-☐☐

Name of college, university, or other educational institution:

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Annual documentation may be required each year after the child's attainment of the limiting age. You must reaffirm student status every year during open enrollment to continue coverage for your dependents.

I affirm under penalties of perjury that the forgoing representations are true.

______________________________ ______________________________
Signature of employee Date