



P.O. Box 24223  
Oakland, CA 94623-1223

## STUDENT VERIFICATION FORM

EMPLOYER NAME	EMPLOYER GROUP NUMBER (IF AVAILABLE)
SUBSCRIBER'S NAME	SUBSCRIBER'S SOCIAL SECURITY NUMBER
STUDENT'S NAME	
NAME OF SCHOOL	DATE ENROLLED

**If your child qualifies as an unmarried, student dependent, please read and sign the following statement:**

I certify that my above-named dependent is an unmarried student. I hereby request continuation of my child's coverage under my group Health Plan with the understanding that I will notify Kaiser Foundation Health Plan immediately if my child marries or ceases to be a full time student.

DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_      Signature of Subscriber \_\_\_\_\_