

Student Coverage Questionnaire

1. Employee's Name _____
2. Employee's ID# (Social Security number) _____
3. Dependent's name _____
4. Dependent's birth date ____/____/____
5. Dependent's relationship to the employee _____
6. Is the dependent: Single? Married? Divorced? Separated?
7. Is the dependent employed? Yes Full-time Part-time No
8. List any other group insurance program the dependent is covered under

9. School name and address _____

10. Type of school (college, trade, etc) _____
11. Is the student full-time or part-time _____
12. Dates of the current school term _____
13. What is the expected date of: (a) course completion _____
(b) Graduation _____

I hereby certify that the above is correct to the best of my knowledge.

Signature of employee

Date

“SCHOOL CERTIFICATION”

NOTE: After completing the above information, forward this form to the school for their certification of questions 9 through 13.

**Signature of Registrar of School
And Imprint of school seal**

Title/Date

*Return to: Caryn Martin
3 Penn Plaza East, Newark NJ 07105 – Mail Station PP-09T*