

**STUDENT VERIFICATION FORM**

Employee Name: \_\_\_\_\_

Employee Alt ID# or SSN#: \_\_\_\_\_

Dependent Name: \_\_\_\_\_

**Failure to submit student verification will result in termination of benefits.**

- A. Total Disabled: Please log onto <http://benefits.sd.gov> to obtain the Incapacitated Dependent Child Form.
- B. Ineligible dependents: Children between ages 26 to 29 that are not a full-time college student. **If ineligible, please complete a Family Status Change Form and attach supporting documentation.** The dependent will be removed off of the plan at the end of the month that he or she became ineligible. The dependent will be eligible for COBRA (continuation of coverage) as stated in the Summary Plan Description.

**C. MUST BE COMPLETED BY REGISTRAR:**

School Term –**Spring**: From: \_\_\_\_\_ To: \_\_\_\_\_

School Term –**Fall**: From: \_\_\_\_\_ To: \_\_\_\_\_

Student Classification: Full-time: \_\_\_\_\_ Part-time: \_\_\_\_\_

I hereby certify that the above information is true and correct to the best of my knowledge:

\_\_\_\_\_ Date

\_\_\_\_\_ School Registrar Signature

**(SCHOOL SEAL REQUIRED)**

**D. Full-time Student (Complete information below)**

Name of Educational Institution: \_\_\_\_\_

City/State where institution is located: \_\_\_\_\_

I understand that I am obligated to inform the Benefits Program of any change my student status. I understand that any misrepresentation in the information I have provided above will result in termination of benefits.

Signed: \_\_\_\_\_  
Dependent Signature

Date: \_\_\_\_\_

**Return to: Dialog Direct  
P.O. Box 8072  
Royal Oak, MI 48068  
Fax: 800.641.9124  
(If faxing, please **do not** mail form.)**

