

COLLEGE STUDENT WAIVER

Mail to:

Preferred Group Plans

P.O. Box 15136

Albany, New York 12212-5136

Atten: Dental Department

Any Questions ? Call toll free 1-800-573-7474

I, _____, am currently attending college on a full time basis (the equivalent of twelve (12) or more credit hours per semester) and am applying for coverage as a dependant student. I understand that my eligibility will end once I have reached the maximum age as stated in my Summary Plan Description or until I am no longer attending school on a full time basis, whichever comes first. Coverage will be under contract for my parent, step-parent, or legal guardian:

EMPLOYEE NAME _____

EMPLOYER _____

SUBSCRIBER ID # _____

NAME OF COLLEGE _____

COLLEGE ADDRESS _____

STUDENT SS # _____ DOB: _____

DATE OF ENROLLMENT FROM _____ TO _____

EXPECTED DATE OF GRADUATION _____

NUMBER OF COURSES PER SEMESTER _____ TL. CREDITS _____

IF NO LONGER FULL TIME STUDENT,
INDICATE THE MONTH AND YEAR LAST
ENROLLED AS A FULL-TIME STUDENT: _____

DATE: _____ SIGNATURE: _____

***DELAY IN COMPLETION OF THIS FORM WILL RESULT IN DELAY OF CLAIMS
BEING PROCESSED***