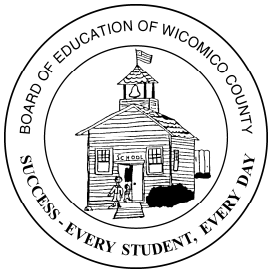


BOARD OF EDUCATION OF WICOMICO COUNTY



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Superintendent of Schools

Fall 2009

Student Certification for Overage Dependent

Group Name Wicomico County Public Schools

Overage Dependent's Name: _____

Overage Dependent's Date of Birth: _____

Name of School: _____

Address of School: _____

I certify that my son/daughter, is unmarried, is financially dependent, and is a full-time student enrolled in an accredited school.

His/her enrollment at the above school began:	Month		Day		Year	
The expected graduation date is:	Month				Year	
Beginning date current semester/trimester:		Ending date current semester/trimester:				

I understand that his/her protection under my coverage will terminate (as defined in the Certificate/Evidence of Coverage) on:

- The end of the calendar year in which the dependent turns 19.
- If the student is a full-time student at age 25, he/she can stay on the coverage until the end of the calendar year.
- The last day of the calendar month in which he/she ceases to be a full-time student

If your Dependent no longer qualifies for coverage, please immediately contact your company's Human Resources Department.

Date

Subscriber Signature

Subscriber Identification Number

Please return this form to: **Bunnie Stanley in the Human Resources Department**

It is the policy of the Wicomico County Board of Education to provide equal educational and employment opportunities regardless of age, gender, race, color, religion, national origin, disability or sexual orientation.