

## 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:

mm/dd/yy

Ending date current  
semester/trimester

mm/dd/yy

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

- The end of the month in which the dependent student turns 25
- 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 Name - Printed

\_\_\_\_\_  
Subscriber Signature

\_\_\_\_\_  
Subscriber Identification Number

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