WellChoice℠

FAX to: 1-800-780-1224
Mail to: WellChoice
PO Box 3509
Church Street Station
New York NY 10008-3509

STUDENT COVERAGE QUESTIONNAIRE

Member's identification number: _____

Dependent's name: _____

1. Dependent's date of birth: _____

2. Relationship to member: _____

3. Is dependent: ☐ Single ☐ Married ☐ Divorced ☐ Separated

4. Is dependent employed? ☐ Yes ☐ Full-time ☐ Part-time ☐ No

5. List any other group insurance or pre-payment program the dependent is covered under:

_____

6. Is the dependent a student ☐ Yes ☐ No If yes: ☐ Full-time ☐ Part-time

7. School name and address: _____

8. Type of school (college, trade, etc.) _____

9. Expected date of: Graduation _____ Course Completion: _____

10. Was the dependent a full-time student at an accredited school who is now on a leave of absence from the school due to illness or injury? ☐ Yes ☐ No

If yes, what is the name of the school attended prior to the medical leave?

_____

What is the date the medical leave began? _____

(You must also attach a letter from the student's doctor which documents his/her illness or injury and certifies to the medical necessity of the leave of absence from the school)

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

_____ _____

Signature of member Date

I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Services and products provided by WellChoice Insurance of New Jersey, Inc. and WellChoice HMO of New Jersey.