CASEBP

Catskill Area Schools Employee Benefit Plan

STUDENT VERFICIATION FORM

EMPLOYER NAME: **Gilboa-Conesville CSD**

EMPLOYEE NAME: ID# :

DEPENDENT NAME: DOB:

Is this Dependent a Student?

☐ NO My dependent was no longer a student as of ____/____/____ (Date).

☐ YES **If yes**, please complete the following questions:

NAME OF SCHOOL: _____

ADDRESS OF SCHOOL: _____

REGISTRAR'S PHONE #: _____

CURRENT SCHOOL SEMESTER (Month/Year): From _____ To _____

DEPENDENT STUDENT IS: ☐ Full-Time ☐ Part-time NUMBER OF CREDIT HRS: _____

WAS DEPENDENT ATTENDING SCHOOL DURING THE LAST SEMSTER: ☐ Yes ☐ No

DATES OF LAST SEMESTER ENROLLED: From _____ To _____

EXPECTED DATE OF GRADUATION (Month/Year): _____

IS STUDENT COVERED BY OTHER INSURANCE: ☐ Yes ☐ No

If yes, name of Policyholder: _____

Name & Address of Other Coverage: _____

_____

Effective Date of Other Insurance Coverage: _____

OTHER INSURANCE COVERS: ☐ Medical ☐ Dental ☐ Prescriptions ☐ Vision

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I certify that the above information is true and understand that I may be held responsible for any overpayment made, on behalf of my dependent, due to misrepresented student information.

EMPLOYEE SIGNATURE: _____ DATE: _____

Proof of College enrollment must be returned with completed form to Samantha DeFreese, GCCS Business Office ASAP to prevent termination of benefit.