



STUDENT CERTIFICATION AFFIDAVIT

I hereby certify that _____
(Student Name) (Social Security Number)

_____ is a full time student at
(Date of Birth)

(Accredited Educational Institution) (Registrar office's phone number)

(City/Town) (State) (Zip)

Date the Semester begins ____ / ____ / ____

I hereby certify that information provided above is true and accurate. I further agree to inform Blue Cross Blue Shield of Massachusetts immediately of any changes in this information. I understand and agree that the above information will be used to determine whether my dependent is entitled to dependent student health care coverage. If I misrepresent or provide false or incomplete information, my membership may be terminated (including retroactively) at the discretion of Blue Cross and Blue Shield of Massachusetts and / or my employer.

I understand that this signed affidavit must be received by Blue Cross Blue Shield of Massachusetts before any coverage can become effective for my dependent.

Date: ____ / ____ / ____

(Subscriber's Signature)

(BCBS of MA Identification Number)

Please return to:

Blue Cross Blue Shield of Massachusetts
P.O. Box 9145
N. Quincy, MA 02171-9145
Fax Number: (617) 246-9659