

Subscriber name: _____ Student: _____
 Address 1: _____
 Address 2: _____ Harvard Pilgrim ID#: _____
 City, State, Zip: _____

FULL-TIME STUDENT VERIFICATION AFFIDAVIT

Note: This form only applies to dependents age 19 and older.

I hereby certify that _____ (Name of student dependent) _____ (Social Security Number) _____/_____/____ (Date of Birth)

is either:

(please check one) **A FULL-TIME student (age 19 and older and unmarried) at**

_____ (Educational institution: high school, college, university, other)

_____ (City/Town) _____ (State)

for the semester ____/____/____ to ____/____/____ or school year _____

Expected Graduation Date: ____/____

OR

Is no longer a full-time student

I hereby certify that the information provided above is correct. I understand that I am obligated to inform Harvard Pilgrim Health Care, Inc. ("HPHC"), including Harvard Pilgrim Health Care of New England ("HPHC-NE") and HPHC Insurance Company, of any change in the noted dependent's student status. To ensure accuracy, I acknowledge and agree that HPHC, including HPHC-NE and HPHC Insurance Company, may investigate the status of the noted dependent during the period in which the dependent is claiming full-time student standing. I understand that any misrepresentation in the information I have provided above will permit HPHC, including HPHC-NE and HPHC Insurance Company, to terminate the dependent's membership and seek any other legal remedies available to HPHC, including HPHC-NE and HPHC Insurance Company.

I understand that the dependent's coverage may not be effective until a signed affidavit is returned to HPHC, including HPHC-NE and HPHC Insurance Company.

Date: _____

 (Signature) Subscriber/Spouse

 (Relation to student dependent)

Please note: This affidavit will only be accepted if signed by the subscriber, parent, stepparent or guardian.
 Fold and return in enclosed envelope or fax to:

Harvard Pilgrim Health Care
 Student Verification Processing
 1600 Crown Colony
 Quincy, MA 02169-9978

FAX: 617-509-1539
 (If faxing, please do not mail form.)



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This information refers to plans offered by Harvard Pilgrim Health Care and its affiliates,
 Harvard Pilgrim Health Care of New England and HPHC Insurance Company.