AFFIDAVIT OF STUDENT INELIGIBILITY

Insured Name: _____ Certificate No.: _____

Dependent's Name: _____

Prior School Name: _____

Prior School Address: _____

Date Student Status Ended: _____

I hereby certify that the above named dependent's status as a full-time student, as defined in the Certificate of Coverage, terminated as of the date stated above.

I understand and acknowledge that:

1. Any claims incurred after the date student status ended will be denied.

2. The insurer is entitled to deduct the amount that has been paid for any claims incurred after the date on which student status ended from any premium refund to which I may be entitled.

3. Because termination is retroactive to the date on which student status ended, the time period for my dependent to enroll in continuation of coverage or conversion coverage has lapsed.

4. Because termination is retroactive to the date on which student status ended, my dependent must submit a new application for coverage, which shall be subject to insurer's underwriting and approval, in order for my dependent to maintain coverage with the insurer.

5. Termination of coverage retroactive to the date on which student status ended may affect my dependent's rights under the Health Insurance Portability and Accountability Act and state law, and may subject my dependent to pre-existing condition exclusions under future health insurance coverage.

_____ _____

Insured's Signature (Certificate Holder) Date

State of _____)
) SS
County of _____)

Subscribed and sworn to before me this _____ day of _____,
200_____, by _____.

_____

Notary Public

My Commission expires _____