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 Attn: Trish Harvey  
 1111 Market Street  
 Chattanooga, TN 37402

**Questionnaire for Verification  
 Of Dependent Eligibility**

<b>DATE</b>	<b>SUBSCRIBER'S NAME (EMPLOYEE)</b>	<b>DEPENDENT'S NAME</b>
<b>NAME OF HEALTHPLAN:</b>	<b>HEALTHPLAN CODE</b>	<b>ID NUMBER</b>
<b>GROUP NAME</b> LSU First		<b>GROUP/DIVISION NUMBER</b> 3330527

Please complete Section A or B, and sign/date this Questionnaire. Return the Questionnaire with the appropriate documentation in the enclosed envelope. Make sure the return address appears in the window.

**A. Full-Time Student Verification**

\_\_\_\_ Named dependent applying for continued coverage under the plan terms (unmarried, primarily supported by the employee, and enrolled in school as a full-time student). Please return this Questionnaire with one of the following forms of verification:

- A copy of the current semester official claim schedule reflecting full-time student status &/or total credit hours; OR
- A signed statement from the Registrar or Dean of Students verifying full-time status; OR
- A copy of the current semester tuition bill showing full-time student status &/or total credit hours

\_\_\_\_ Named dependent does not qualify for continued coverage under the plan terms.

**B. Handicapped/Disabled Dependent Verification**

\_\_\_\_ Named dependent applying for continued coverage under the plan terms (disabled/handicapped and incapable of self-support). Please return this Questionnaire with the following documentation from the attending physician:

- Date of initial occurrence;
- Diagnosis;
- Degree/Severity of disability;
- Current medications, treatments, therapies;
- Prognosis of disability;
- Statement of patient's ability to be self-supporting; AND
- Attending physician's name, address and telephone number

\_\_\_\_ Named dependent does not qualify for continued coverage under the plan terms.

**Authorization/Release of Information:** I certify that all the information I have provided is true and correct to the best of my knowledge. A copy of this authorization shall be valid as the original. I hereby authorize any insurance company, administrator, prepaying organization, employer, pharmacy, hospital, physician, or organization to release all information with respect to myself or my dependents that may have a bearing on the eligibility of coverage.

Verification of dependent eligibility will be requested periodically.

**Signature of Employee/Subscriber:** \_\_\_\_\_ **Date:** \_\_\_\_\_