Bahama Health
FEEL GOOD ABOUT YOUR HEALTHPLAN

The group division of Family Guardian Insurance Company Limited

STUDENT VERIFICATION FORM

Employee Name:		**Member ID Number:**	
Group Name:		**Group Number:**	
Student Name:		**Date of Birth:**	(mm/dd/yyyy)
Name of College/ University:			
Address of College/University:			
Current Semester Date:	☐ Spring/Winter ☐ Full Time	☐ Fall ☐ Part Time	Year: _____
Expected Date of Completion:			
Authorized Name:			
Authorized Signature:			
Title:			

Place Official School Stamp Here

To continue coverage, eligible dependents of the maximum dependent age that are not currently enrolled as full time students should submit a request for conversion to the individual BahamaHealth plan within 31 days of attaining age 19.

I understand that my dependent's coverage will terminate: -

If he/she ceases to be a full-time student
If he/she marries or becomes gainfully employed
When he/she attains his/her twenty-fifth (25) birthday

To be completed by Member:

I declare that all statements on this form are complete and true and I understand that they are the basis on which insurance may be maintained under this plan.

Employee Signature:		**Date:**	(mm/dd/yyyy)
Dependent Signature:		**Date:**	(mm/dd/yyyy)

If the school did not complete and stamp this form, other documents verifying full-time enrollment must be attached. Example: A class schedule and billing statement/recent proof of payment or letter of student status. Student status confirmation must be submitted twice annually (Fall and Spring/Winter).