



STUDENT RECERTIFICATION

Subscriber Name: _____

Address: _____

Dependent Name: _____

HIP ID #: _____

The dependent whose name appears above will no longer be entitled to dependent coverage under your HIP policy. You may, however, continue to keep the dependent on your policy if she/he is unmarried and either:

1. A full-time student at an accredited institution of learning; or
2. Unable to work or support himself/herself because of mental illness, developmental disability, mental retardation or physical handicap. You must submit proof of the disability and/or condition within 31 days.

If one of the above applies, complete BOTH requirements of this letter (Subscriber Attestation and Proof of Status) and mail, along with the appropriate documentation, to:

HIP Health Plan of New York
 P.O. Box 2794
 New York, NY 10117

or fax all documents together, to the attention of: **STUDENT RECERTIFICATION 1-646-447-3089.**

To ensure proper recording of this information, indicate the dependent's HIP ID # on all documents faxed.

Failure to complete and return this document will result in termination of coverage for the above-named dependent.

If you have any questions, contact our Customer Service department at **1-800-HIP-TALK (1-800-447-8255)** Monday through Friday 8 am to 6 pm.

SUBSCRIBER ATTESTATION (Spouse or dependent signature not acceptable.)

- Full-time student? Yes No
- Is this dependent handicapped? Yes No

I certify that this dependent is an unmarried child currently attending an accredited educational institution.

Subscriber's signature _____

Date _____

THIS SECTION TO BE COMPLETED BY THE EDUCATIONAL INSTITUTION ONLY
 (or attach certificate from Registrar's Office regarding full-time student status)

PROOF OF STATUS

Name of Institution: _____

Address: _____

Telephone: (_____) _____ - _____

This is to confirm that _____ is registered as a full-time student.

Registrar's signature _____

Date _____