PLEASE COMPLETE THE FOLLOWING FOR DEPENDENT STUDENTS AGE 19 OR OLDER*

(*Certain Empire Plan employer groups allow coverage until a dependent reaches age 21 before enrollment verification is needed. These include: PBA – PIA, PBA – Supervisors, PBA - Troopers)

Empire Plan Enrollee's Name: _____

Empire Plan Identification # (from NYSHIP Benefit Card): _____

Dependent Student's Name: _____

Student's Social Security #: _____

Name, address, & telephone number of school:

Current Semester Enrollment:
From _____ To _____ ❑ full-time ❑ part-time

Previous Semester Enrollment(s):
From _____ To _____ ❑ full-time ❑ part-time
From _____ To _____ ❑ full-time ❑ part-time
From _____ To _____ ❑ full-time ❑ part-time
From _____ To _____ ❑ full-time ❑ part-time
From _____ To _____ ❑ full-time ❑ part-time
From _____ To _____ ❑ full-time ❑ part-time
From _____ To _____ ❑ full-time ❑ part-time

Type of School (ie, college, trade, etc.): _____
Course of Study: _____

Except for regular vacation periods, was student in attendance during entire period covered by this claim?
❑ yes ❑ no
If no, explain:

Anticipated date of graduation:
Month _____ Year _____

Is student employed?
❑ full-time ❑ part-time ❑ not employed

Is full-time employment only during non-school periods?
❑ yes ❑ no ❑ not applicable

Name, address, & telephone number of employer:

Student's Marital Status:
❑ single ❑ married ❑ widowed ❑ divorced

Is student covered by another insurance plan?
❑ yes ❑ no
Name, address, & ID# for other plan:

If dependent has had military service, give dates:

From _____ To _____

NYS RESIDENTS – *The following statement is printed pursuant to Regulation 95 of the New York State Insurance Department:*
Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for such violation.

RESIDENTS OF STATES OTHER THAN NEW YORK – *NOTICE:*
Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

I have read the appropriate statement above and authorize release of any information necessary to process claims.

a. PATIENT/AUTHORIZED PERSON'S SIGNATURE: _____ DATE: _____

b. ENROLLEE/AUTHORIZED PERSON'S SIGNATURE: _____ DATE: _____

SUBMIT TO:
EMPIRE PLAN • UNITED HEALTHCARE INSURANCE COMPANY OF NEW YORK • PO BOX 1600 • KINGSTON, NY 12402-1600