

## STATE OF NEW YORK

### STUDENT VERIFICATION FORM – VISION CARE

**DEPENDENT STUDENT:** An unmarried child, who is a full time student, will be covered through age 24. *(Dependent must be considered a full-time student by the school attended.)*

TO BE COMPLETED FOR DEPENDENT STUDENTS AGES 19 THROUGH 24 WHO WILL BE USING THE PLAN. Please return this form to EyeMed Vision Care via US postal mail, email, or fax at least 10 days before services will be requested.

I certify that my dependent, \_\_\_\_\_, \_\_\_\_\_  
(PRINTED NAME) (DATE OF BIRTH)

is unmarried, and is enrolled full-time in an accredited secondary or preparatory school or college. I agree to advise EyeMed Vision Care promptly of any changes in my child's dependent student status.

Name of School: \_\_\_\_\_ Location: \_\_\_\_\_

Semester starts: \_\_\_\_\_ Semester ends: \_\_\_\_\_

\_\_\_\_\_  
Enrollee's Printed Name

\_\_\_\_\_  
Enrollee's Social Security Number

\_\_\_\_\_  
Enrollee's Signature

\_\_\_\_\_  
Date

Please return form to EyeMed Vision Care via one of the following methods:

1. Mail to: EyeMed Vision Care  
Attn: Membership  
4000 Luxottica Place  
Mason, OH 45040
2. Fax to the attention of "EyeMed Vision Care – Membership" at 513-492-3605.
3. Email Address: [Enroll@eyemedvisioncare.com](mailto:Enroll@eyemedvisioncare.com)

*Any person who knowingly and with the intent to defraud any 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 also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claims for each such violation.*