Physicians Health™
BENEFIT TRUST

Submit to:
MBA of MD, Inc.
PO Box 950
Forest Hill, MD 21050-0950

p 888.532.3467
f 410.877.2004

Legal Name: PHA Group Benefit Trust
Version: PHBT / FTS / 0308

CERTIFICATION OF FULL-TIME STUDENT ELIGIBILITY

Please complete this form in "**BLACK**" ink only and print legibly

Our records indicate that one or more of your dependents are over the age of 19. In order for your dependent to remain on your coverage past this limiting age, please complete the certification below.

Employee Name: _____ Employee Social Security No | | | | - | | | - | | | | |

SECTION I. DEPENDENT'S INFORMATION

Dependent's Name: _____ Dependent's Date of Birth: _____

Dependent's Sex: M / F Dependent's Social Security No | | | | - | | | - | | | | |

Do You Provide 50% of the Dependent's Yes / No Relationship to Employee: _____

Does the Dependent reside with you? Yes / No Dependent's Marital Status: Single / Married / Divorced / Seperated

I hereby certify that the inforamtion contained on this form is correct to the best of my knowledge and authorize the release of any inforamtion requested with respect to this certifaction.

Employee Signature: _____ Daytime Telephone Number: _____ Date: _____

SECTION II. STUDENT CERTIFICATION: School Official to complete this section if dependent is eligible based on student status (subject to the plan options selected by your employer)

School Name: _____ School Address: _____

_____

Beginning and Ending Date of Current Semester: _____ to _____

Which Semester does this certification apply? Fall / Spring Is this Institution accredited? Yes / No

Credit Hours per Current Semester (Classroom Hours per Week): _____

What is the student status as determined by the institution: Full-time / Part-time

SUMMER SESSIONS

Is Student currently enrolled for a summer session? Yes / No

If Yes, Did Student Attend Spring Semester Preceding Break? Yes / No

Is Student Enrolled for the Fall Semester? Yes / No

I hereby certify that the above information is correct to the best of my knowledge.

Signature of School Official: _____ Daytime Telephone Number: _____ Date: _____

Please note: the member must complete the top portion of this form and attach a letter from the College Registar's office. Please be advised that the letter from the College Registar's office must be on official school stationary and be signed by the School's Administrative office or Registar's office. The information must state the dependent's name, and indicates that the dependent is a full-time student for the **Current** semester. You may also attach documentation of payment on official school stationary showing the **PAID** Full-time tuition that states the dependent's name and states that this dependent is a full-time student for the **Current** semester.

We will not accept a copy of an unpaid tuition bill as verification of full-time student status.