

Affidavit of Student Status for Dependents

This form is to be completed by the student's parent or legal guardian.

Name of Student: _____ Date of Birth: ____/____/____
(Please Print)

Name of Accredited Institution of Learning that dependent is attending as a full-time* student:

Address of Accredited Institution of Learning: _____

Phone Number: _____

**Note: Full-time student status is defined as enrollment in a minimum of 12 credits per semester.*

Semesters Attending: _____ # of Credits per Semester: _____
(Semester / Year)

_____ # of Credits per Semester: _____
(Semester / Year)

Anticipated Date of Graduation: ____/____/____

Insured Parent's Name: _____
(Please Print)

Insured Parent's Employer: _____

Insured Parent's Vytra ID #: _____ Student's Vytra ID #: _____

If student is covered by another Vytra Health Plans ID number, please list the number and the name of the other policyholder: _____

Authorization:

By signing this affidavit of full-time student status, I certify that under penalty of perjury that all statements contained in this certification are true to the best of my knowledge. I understand that any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed the limits defined in the Insurance Law and the stated value of the claim for each such violation.

Signature of Parent or Legal Guardian: _____ Date: ____/____/____

Print Name of Parent or Legal Guardian: _____

**Please return this form to:
HIP/Vytra • Attn: Enrollment Department • PO Box 2974 • New York, NY 10117-3255
Fax: 646-447-3089**

*Your Account Management team is available to answer any questions you may have.
Please contact them for assistance.*

