Avera Health Plans

Student Verification Form

Section 1 – To be completed by subscriber

Student Name: _____ Subscriber #: _____

Date of Birth: _____ Group #: _____

Subscriber Name: _____

Is your dependent a **full-time** student for the current semester? Yes _____ No _____

If Yes, the School Registrar must complete Section 2.

If No, state reason: ____ Graduation Date: _____ / _____ / _____

____ Marriage Date: _____ / _____ / _____

____ Other Date: _____ / _____ / _____

Subscriber Signature: _____ Date: _____ / _____ / _____

Section 2 – To be completed by the registrar's office

Is the student listed above enrolled **full-time** for the current semester? Yes _____ No_____

If Yes, Semester Start Date: _____ / _____ / _____

Semester End Date: _____ / _____ / _____

Anticipated Graduation Date: _____ / _____ / _____

If No, when did the student terminate full-time student status? Date: _____ / _____ / _____

Name of School: _____

Address (City, State and Zip Code): _____

Telephone: (_____) _____ - _____

Is this an accredited school? Yes _____ No _____

CERTIFICATION

I certify that the school information stated above is true and correct.

Registrar Signature: _____ Date: _____ / _____ / _____

Official Seal Required

Mail to Avera Health Plans, Attn: Enrollment, 5300 S Broadband Ln, Sioux Falls, SD 57108-2221 or fax to 605-322-4689. You may send it electronically by email to ahpenrollment@avera.org
Our Customer Care Team is available Monday through Friday at 605-322-4545 or toll-free at 888-322-2115