

**STATE SYSTEM OF HIGHER EDUCATION  
STUDENT CERTIFICATION FORM**

Employee/Annuitant Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Daytime Phone Number: \_\_\_\_\_

Student's Name: \_\_\_\_\_

Student's Social Security Number: \_\_\_\_\_

Student is:                     Single       Married       Divorced

Student's Date of Birth: \_\_\_\_\_

Relationship: \_\_\_\_\_

If student is not blood descendant of the first degree, does student reside with you when not attending classes on a full-time basis?       Yes       No

Type of Student:                     Full-time       Part-time

College, University, or Learning Facility,  
which Student Attends: \_\_\_\_\_

Semester Start Date: \_\_\_\_\_

Expected Date of Graduation: \_\_\_\_\_

I hereby certify that the above-named student qualifies as my dependent child, and I agree to provide proof of relationship and age as may be required. I further acknowledge that if the above-named dependent ceases to be a full-time student, it is my responsibility to immediately notify the Office of Human Resource Management. If I fail to notify Human Resources within 60 days of the date the dependent ceases to be a full-time student, I further acknowledge that the student will be unable to continue this group insurance on a direct-pay basis under the provisions of the Federal Law, known as COBRA.

\_\_\_\_\_  
Signature of Employee/Annuitant

\_\_\_\_\_  
Date