COMMON GROUND
HEALTHCARE COOPERATIVE

FULL-TIME STUDENT CERTIFICATION FORM

POLICYHOLDER INFORMATION	
Policyholder Name:	Member ID Number:
Policyholder Address:	
Policyholder Phone Number:	Policyholder Email:

DEPENDENT STUDENT INFORMATION	
Dependent Name:	Dependent Date of Birth:
Dependent Address:	
Is the dependent a full-time student: ☐ Yes ☐ No	Number of credits:
Name of School:	
Address of School:	
Date initially enrolled in school:	Estimated date of graduation:

PROOF OF ENROLLMENT

Proof of enrollment must be returned with this form. Please enclose one of the following items:

☐ Class schedule
☐ Tuition bill
☐ Letter from Registrar's office

Please note that you must notify CGHC within five days if the dependent student falls below full-time status.

SIGNATURE

By signing this form, you attest that the information provided above and below is true. You understand and agree that it is your responsibility to notify Common Ground Healthcare Cooperative of any change in the full-time student status of your dependent child.

I hereby certify that the information provided above is correct. I understand that any misrepresentation in the information I have provided above will permit Common Ground Healthcare Cooperative to deny claims, terminate coverage and seek any other legal remedies available to Common Ground Healthcare Cooperative.

_____ _____

Policyholder Signature Date

Mail to: CGHC, PO Box 1630, Brookfield, WI 53008-1630 or Fax to: 262.754.9690

If you have any questions about this form, please call Member Services at 877.514.2442