



# AFFIDAVIT OF STUDENT STATUS FOR DEPENDENTS

This form is to be completed by the Parent or Legal guardian of the student.

Name of Student: \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

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

Address of Accredited Institution of Learning: \_\_\_\_\_

Phone Number of Accredited Institution: ( \_\_\_\_\_ ) \_\_\_\_\_

*\*Note: Student must be taking a minimum of 12 credits to be considered full time.*

Semesters attending: Fall \_\_\_\_\_ Year \_\_\_\_\_ # of credits per semester: \_\_\_\_\_

Spring \_\_\_\_\_ Year \_\_\_\_\_ # of credits per semester: \_\_\_\_\_

Anticipated Date of Graduation: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Insured Parents Name: \_\_\_\_\_

Insured Parents Employer: \_\_\_\_\_

Insured Parents Vytra ID No: \_\_\_\_\_ Student's Vytra ID No: \_\_\_\_\_

### 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, information 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: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Print Name: \_\_\_\_\_

Failure to complete this affidavit and return it to Vytra Health Plans within 30 days of the date of the attached letter will result in the termination of coverage for this dependent without any further notification from Vytra.

It is the parent or legal guardians responsibility to notify the employer if the dependent changes to part time or discontinues school.

Return this form to the Enrollment Department at:

Vytra Health Plans, Corporate Center, 395 North Service Road, Melville, NY 11747-3127  
(631) 694-6565 Fax (631) 249-6697