STUDENT VERIFICATION FORM

Employee Name:_____

Employee Alt ID# or SSN#:_____

Dependent Name:_____

Failure to submit student verification will result in termination of benefits.

A. Total Disabled : Please log onto http://benefits.sd.gov to obtain the Incapacitated Dependent Child Form.

B. Ineligible dependents: Children between ages 26 to 29 that are not a full-time college student. **If ineligible, please complete a Family Status Change Form and attach supporting documentation.** The dependent will be removed off of the plan at the end of the month that he or she became ineligible. The dependent will be eligible for COBRA (continuation of coverage) as stated in the Summary Plan Description.

C. **MUST BE COMPLETED BY REGISTRAR:**

School Term –**Spring**: From: _____ To:_____

School Term –**Fall**: From: _____ To:_____

Student Classification: Full-time:_____Part-time:_____

I hereby certify that the above information is true and correct to the best of my knowledge:

_____ _____

Date School Registrar Signature

(SCHOOL SEAL REQUIRED)

D. Full-time Student (Complete information below)

Name of Educational Institution: _____

City/State where institution is located: _____

I understand that I am obligated to inform the Benefits Program of any change my student status. I understand that any misrepresentation in the information I have provided above will result in termination of benefits.

Signed: _____ Date:_____

Dependent Signature

Return to: **Bureau of Human Resources**
Att: Benefits Program
500 East Capitol
Pierre SD 57501
Telephone: 605.773.3148
Fax: 605.773.6840
(If faxing, please **do not** mail form.)

SOUTH DAKOTA
state employee
benefits program
learn. act. thrive.