MEBA MEDICAL & BENEFITS PLANS
1007 EASTERN AVE
BALTIMORE, MD 21202

Date: ____________________________________

____________________________________ Member: ________________________________

____________________________________ SSN: ____________________________________

____________________________________ Dependent: ______________________________

Dear Participant:

Our records indicate that your dependent, ___________________________, is between the ages of 19 and 23.

Article XVIII, Section 1 (c) (ii) of the Regulations of the MEBA Medical and Benefits Plan (the "Plan") contains a provision that extends eligibility for a dependent child from age 19 up to age 23, provided the child is attending school as a full-time student.

Please furnish a statement, letter, or the enclosed Student Status Verification Form completed and signed by an authorized representive of the school that indicates the above listed dependent is attending school on a full-time basis. Verification must include the semester(s) or time period your dependent will be attending school on a full-time basis for the academic year. Our office must receive this information no later than September 15th of each year to avoid processing delays.

While the Plan will accept the Student Status Verification form for the entire academic year, we wish to remind you that your statement represents your verification that your dependent child is attending school throughout the year on a full-time basis. If this situation should change (i.e., if your dependent child will not be returning to school or is no longer a full-time student), you must notify the Plan immediately, so that our records can be adjusted. Any overpayments made in reliance on your statement are due the Plan, if necessary, will be deducted from future benefit payments to you or to your providers. For information regarding continuation of benefits on a self-pay basis, please contact our Cobra Coordinator.

You may also obtain a Student Status Verification Form from the Plan Office in Baltimore, or on the Plan's website at www.mebaplans.org. Please feel free to contact us at 410-547-9111, or toll free, at 1-800-811-MEBA if you have any question about dependent coverage or about the Plan in general.

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Member Services Department
MEBA Medical & Benefits Plan

STUDENT STATUS VERIFICATION FORM
THE FOLLOWING MUST BE COMPLETED BY AN AUTHORIZED REPRESENTATIVE OF THE SCHOOL

Date: ________________________

___________________________________ Member: _____________________

___________________________________ SSN: ________________________

___________________________________ Dependent: ___________________

This is to certify that __________________________ is attending, as a full time student,

Name of school ____

Address of School ____

____

Enrollment Date: ____

Anticipated Graduation Date: ____

Semester Date(s) Fall: _____________________ winter: _________________

Spring: ___________________ Summer: _______________

This student is _____ is not _____ covered by student insurance. If yes, for Medical & Accident _____________________ Accident Only ____________________________
Name of Insurance Company ____
Address ____________________________ Policy No __________________________

I hereby certify that this information is accurate.

Signature____
Title ____
Phone No ____

REV.08/03 M/S