



Health Net®
A Better Decision

STUDENT VERIFICATION FORM

Employee Information	Last Name		First Name	
	Address			
	City		State	Zip
Employer Information	Name			
Dependent Information	Identification # (listed on ID card)		Billing Code (03, 04, etc. listed on ID card)	
	Last Name		First Name	
School Information	Name of School (Accredited Institution)			
	City			State

I certify that my dependent is a full-time student. I understand that it is my responsibility to notify Health Net within 31 days if my dependent becomes ineligible due to marriage or loss of full-time student status.

Signature of Employee

Date

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