Student Status-Request for Information

Please return to:
Arlington Teachers' Association
C/O Preferred Group Plans Inc.
PO Box 15136
Albany NY 12212-5136

Name of Dependent Student_____Social Security Number_____

Name of Insured_____ Social Security Number _____

Dependents Date of Birth_____ Relationship to insured_____

Is Dependent: ☐ single ☐ married ☐ divorced ☐ separated

Is Dependent Employed? ☐ yes ☐ no ☐ full time ☐ part time

List any other group insurance or pre-payment program the dependent is covered under.

_____

_____

School Name _____

School Address_____

_____

Type of School (College, Trade, etc.)_____

Expected Date of Graduation: _____

Was the dependent a full-time student at an accredited school who is now on a leave of absence from the school due to illness or injury? ☐ yes ☐ no

If yes, what is the name of the school attended prior to the medical leave?_____

What is the date the medical leave began? _____

(You must also attach a letter from the Student's doctor which documents his/her illness or injury and certifies to the medical necessity of the leave of absence from the school.

I hereby certify that the above is correct to the best of my knowledge.

Signature of Member Date