

DEPENDENT CERTIFICATION FORM FOR RHODE ISLAND BASED EMPLOYER GROUPS

Subscriber's name: _____

Subscriber's Tufts Health Plan ID number: _____ - _____ - _____

I certify that: _____ / _____ / _____
(Name of dependent) (Date of Birth)

Is currently a: (check one)

FULL-TIME STUDENT PART-TIME STUDENT

At: _____ (Name of accredited educational institution)
_____ (Institution address)
_____ (Institution City, State and Zip)
_____ (Registrar's telephone number)

Expected date of graduation from college: _____ / _____

Is NOT A FULL-TIME OR PART-TIME STUDENT**

The dependent has a medical condition that resulted in a medically necessary leave of absence from, or change in enrollment at a post secondary educational institution. This leave started on _____
(A completed physician certification form must be submitted. This form can be found at www.tuftshealthplan.com)

I further certify that the information I have provided above is true and correct, and that I understand that:

- Tufts Health Plan may contact the educational institution and take any other steps it feels necessary to verify the accuracy of the information I have provided.
- If there is any misrepresentation in the information I have provided, Tufts Health Plan may end my dependent's coverage as well as my entire family's coverage, and may seek any other legal remedies available.

Subscriber's signature: _____ Date: _____
(Must be Employee's signature)

Please return this completed and signed form to:
Tufts Health Plan
Commercial Enrollment and Premium Billing Department
P. O. Box 9186, Watertown, MA 02471-9186
Fax: 617-923-5898

* Rhode Island law requires family policies (for fully insured plans) to include coverage for unmarried student dependents under the age of 25. The State of Rhode Island considers a student dependent to be a dependent enrolled in at least two courses or four credits in a post secondary educational institution (part-time student).

**On October 9, 2009, new federal law went into effect (P.L. 110-381) that provides for a continuation of coverage for those dependents that would otherwise lose eligibility because of a medically necessary leave of absence from a post secondary educational institution or a change in enrollment from that institution.

The leave of absence must be medically necessary and must begin while the dependent is suffering from a serious illness or injury, and the leave of absence would otherwise cause the dependent to lose coverage under the plan.

The dependent must have been enrolled in the group health plan prior to the first day of the leave or change in enrollment. There must also be written certification by the dependent's attending physician indicating that the dependent is suffering from a serious illness or injury that necessitates the leave or change in enrollment status.

Coverage will be extended for up to one year or to the date on which coverage would otherwise terminate under the terms of the plan, whichever comes first.