COLLEGE STUDENT WAIVER

Mail to:

Preferred Group Plans
P.O. Box 15136
Albany, New York 12212-5136
Atten: Dental Department

Any Questions ? Call toll free 1-800-573-7474

I, ______________________________, am currently attending college on a full time basis (the equivalent of twelve (12) or more credit hours per semester) and am applying for coverage as a dependant student. I understand that my eligibility will end once I have reached the maximum age as stated in my Summary Plan Description or until I am no longer attending school on a full time basis, whichever comes first.
Coverage will be under contract for my parent, step-parent, or legal guardian:

EMPLOYEE NAME

____

EMPLOYER BYRAM HILLS TA BENEFIT FUND

SUBSCRIBER ID #____

NAME OF COLLEGE____

COLLEGE ADDRESS____

____

STUDENT SS #______________________ DOB:______________________

DATE OF ENROLLMENT FROM__________________ TO__________________

EXPECTED DATE OF GRADUATION______________________________________

NUMBER OF COURSES PER SEMESTER____________TL. CREDITS__________

IF NO LONGER FULL TIME STUDENT,
INDICATE THE MONTH AND YEAR LAST
ENROLLED AS A FULL-TIME STUDENT:______________________________

DATE:____________________ SIGNATURE:______________________________

DELAY IN COMPLETION OF THIS FORM WILL RESULT IN DELAY OF CLAIMS BEING PROCESSED

Registrar's Signature ________________________ Date ______________
(Required)