

Screen Actors Guild – Producers Health Plan

STUDENT CERTIFICATION FORM

Participant Name: _____

Dependent Name: _____

Address: _____

Dependent Birthdate: _____

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ELIGIBLE PARTICIPANT MUST COMPLETE AND AGREE TO THE FOLLOWING

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I certify that my unmarried child referenced above is:

- 1) Dependent on me for financial support of more than 50%.
- 2) A full-time student at an accredited college or vocational school (the Health Plan considers 12 units as full-time)

Number of Credits/Units: _____ Enrollment Period: _____ to: _____
(mm/dd/yy) (mm/dd/yy)

Check One: Semester _____ Quarter _____

School Name: _____ School Phone: _____

School Address: _____

The Health Plan reserves the right to conduct an audit to verify that your child was a qualified full time student for any period that you have indicated above. If the Health Plan finds that your child was not a qualified full-time student during any period of time that you have certified, you will receive a separate notice informing you of your financial responsibility for any expenses paid out by the Health Plan for the ineligible period(s). If you do not refund the amount that is requested, the Health Plan may withhold any reimbursement otherwise due you and your qualified dependents under the Health Plan and offset that amount against the amount you owe the Plan, including benefits payable for prescriptions, dental and mental health.

I also understand that I must notify the Screen Actors Guild – Producers Health Plan immediately if my child graduates or is no longer considered a qualified full-time student. If I do not notify the Health Plan of either of these two conditions within 60 days in writing, I will forfeit my child's rights to the Plan's Self-Pay Program . I understand that I will be responsible for ay expenses paid by the Health Plan on behalf of my child for services incurred after he/she graduates or is no longer considered a qualified full-time student.

Eligible Participant's Signature

Date