



ASSURANT Health

DEPENDENT VERIFICATION FORM

The completion of this form by the policyholder verifies dependent eligibility as detailed in the attached letter. Please complete the appropriate section and send form to: Union Security Insurance Company, 501 West Michigan, P.O. Box 624, Milwaukee, WI 53201-0624, Telephone: 800-444-6254.

GENERAL INFORMATION

Primary Insured's Name _____ Birthdate _____

Dependent's Name _____ Birthdate _____

Policy/Group Number _____ Cert Number (If applicable) _____

SECTION ONE - STUDENT STATUS

Student's Name _____

Social Security Number _____ Semester From _____ to _____

School's Name _____

This is to verify the above stated individual is a student, as defined by the school, in an institution of higher learning. Please check full or part-time status.

_____ Full-Time Status _____ Part-Time Status

I hereby certify that the above named dependent is a student.

(Signature of primary insured) _____ Date _____

SECTION TWO - DEPENDENT STATUS DUE TO PHYSICAL OR MENTAL HANDICAP

I hereby certify that the above named dependent resides in my household and is dependent upon me for support due to a physical or mental handicap.

(Signature of primary insured) _____ Date _____

Please mail the completed form to the address stated above in the enclosed envelope. We suggest that you give this matter your immediate attention to avoid terminating health insurance for an eligible dependent.

*** Medical records must be submitted if your dependent is unable to be self-supporting due to mental or physical handicap.**

Health Administration