# Verification of Dependent Status Form

FCHP/FHLAC subscriber certification #: ______________________________

**I hereby certify that** ______________________________ ___/___/___
Dependent's name Date of birth

is a Massachusetts resident (HMO and non-students only), under age 26, and;

☐ a full-time student at an accredited school (complete Full-Time Student Coverage Information below);

**or** is not a full-time student at an accredited school, but falls into one of the following categories:

☐ claimed or eligible to be claimed as a dependent on federal income tax filings within the past two calendar years by the subscriber or the subscriber's spouse. Indicate most recent year claimed or eligible to be claimed: _____________

☐ eligible as a dependent based on IRS Code, for health care coverage purchased by the subscriber or the subscriber's spouse within the past two calendar years. Indicate most recent year eligible: _____________

☐ Please remove my dependent from my coverage.

FULL-TIME STUDENT COVERAGE INFORMATION

Accredited educational institution: ____________________________________________________

City/town: ________________________________________________ State: __________

Registrar's telephone number: ___________________ Date semester begins: ____/____/____

Expected date of graduation: ____/____/____

*I hereby certify that the information provided is true and accurate. I understand that I am obligated to notify Fallon Community Health Plan ("FCHP"), including Fallon Health & Life Assurance Company, Inc. ("FHLAC"), immediately if there is a change in my dependent's status. To ensure accuracy, I permit FCHP, including FHLAC, to take any steps it considers necessary to verify the accuracy of the information I have provided. I understand that FCHP, including FHLAC, reserves the right to audit claims and that any misrepresentation in the information I have provided will permit terminating the dependent's membership at the discretion of FCHP, including FHLAC.*

**Please note that details as outlined above are subject to change at any time as regulations are further defined by the Commonwealth of Massachusetts legislature.**

Employer name (If applicable): _________________________________ Effective date: _______________

Subscriber name: ___________________________________________

______________________________________________ __________________
Subscriber's signature Date

**Please return this completed and signed form by mail or fax to:**

Fallon Community Health Plan Service Operations
10 Chestnut St. Worcester, MA 01608-2810
Phone: 1-800-868-5200 (TDD/TTY: 1-877-608-7677)
Fax: 1-508-831-1136