



Mail to:
MVP Health Care
Employer Account Services
P.O. Box 2207
Schenectady, NY 12301-2207

College Student Waiver

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 dependent college student. I understand that my eligibility will end once I have reached the maximum age as stated in my MVP Contract, Summary Plan Description or Certificate of Coverage, or I am no longer attending college on a full-time basis, whichever occurs first.

Coverage would be under a Contract, Plan or Certificate of Coverage held by my parent/step-parent/legal custodian or guardian:

Subscriber's Name: _____

Name of Subscriber's Employer: _____

Student/Dependent's Name: _____

Student's Social Security Number: _____ Date of Birth: _____

Student/Dependent's MVP I.D. Number: _____

Name of College or University: _____

College Address: _____

College Registrar's Phone Number: _____

Dates of Current Enrollment: From (Month/Year): _____ To (Month/Year): _____

Expected Date of Graduation: (Month/Year): _____

Current Number of Credit Hours: _____

If you are no longer a full-time student, please indicate the month and year you were last enrolled as a full-time student: _____

Student's Signature: _____ Date: _____

Please note: This form must be completed and submitted to MVP annually.

Any Questions? Call toll-free 1-888-MVP-MBRS or visit our Web site at mvphealthcare.com.