



Corporate      2425 James Street      315.432.9171      www.pomcoinc.com  
Headquarters      Syracuse, New York 13206      315.437.9466 fax

Date

Employee Name  
Street  
State, Zip

ID #

Dependent:

### FULL-TIME STUDENT CERTIFICATION AFFIDAVIT

Completion of this affidavit confirms that the above listed dependent is nineteen years or older and qualifies as a full-time student under your Health Plan. On behalf of your employer, POMCO must receive this form within 30 days of the date of this letter. **If this letter is not returned to the address listed above within 30 days of the date of this letter, benefits for your dependent will be terminated.**

When you enroll a dependent as a full-time student, you are stating that the dependent meets the requirements of an eligible dependent under the defined terms of your employer's health benefit plan. Full-time student eligibility is detailed in the eligibility section of your Summary Plan Description.

I confirm that the information I have provided on this Full-time Student Certification Affidavit is accurate and current. I understand that:

- I may be required, at any time, to provide documentation regarding the full-time student status of any dependent that I am covering under my employer's health benefit plan at any time. Acceptable documentation may include, but is not limited to proof of full-time student status in an accredited school of higher education, College or University, enrollment verification from registrar's office, etc.
- I agree to immediately notify my employer of any change in my dependent's status as a full-time student should my dependent no longer meet the plan's eligibility requirements.
- Coverage of any dependent not meeting the criteria of a full-time student will be cancelled retroactive to the date the dependent no longer meets the plan's eligibility requirements and I will be responsible for any claims incurred on my dependent's behalf.

I further understand that this Full-time Student Certification Affidavit must be completed accurately and truthfully. I agree that if this affidavit is not truthful, I may be subject to disciplinary action up to and including termination of employment and retroactive loss of health plan coverage.

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Employee Signature

Date