PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

MS 188
P.O. Box 327
Seattle, WA 98111

October 18, 2007

«Sub_First_Name» «Sub_Last_Name»
«Address_1»
«Address_2»
«City» «ST» «Zip»

DEPENDENT CHILD NOTIFICATION

Dear University of Alaska Employee:

According to our records, your child has reached the maximum age of 19 and is no longer eligible to receive benefits under the University Plan.

DEP'S NAME: «First_Name» «Last_Name» DATE OF BIRTH: **«DOB»**
SUB'S NAME: «Sub_First_Name» «Sub_Last_Name»
CURRENTLY ON GROUP: **«Group_ID»** UNDER EMP ID: **«Sub_ID»**
DEPENDENT COVERAGE SCHEDULED TO END: **September 30th, 2007**

However, your University of Alaska plan allows your child extended coverage for one of the reasons listed below. Please check the condition(s) below that apply to your dependent.

☐ Blue Cross Blue Shield of Alaska records are incorrect. My child's date of birth is____________.

☐ My child is a full-time student, unmarried, under **24** years old and is dependent upon me as specified under the University of Alaska Health Care Plan. He or she meets the full-time student criteria and is still eligible for coverage.

ATTACHED IS THE VERIFICATION OF ENROLLMENT TO BE COMPLETED BY THE COLLEGE/UNIVERSITY'S REGISTRAR AND RETURNED TO BLUE CROSS BLUE SHIELD OF ALASKA

☐ My child is disabled and incapable of self-sustaining employment. Please send me the appropriate form so that I may furnish proof of my child's dependency in order to continue coverage under my plan.

If your child does not qualify for extended coverage due to one of the conditions above, please check the box below.

☐ My child is not eligible to continue under my University of Alaska plan for any of the above reasons. I understand he or she will be canceled from University of Alaska Health Plan the last date shown above. **You must contact your local campus personnel office to make changes to your plan.**

If your child does not qualify for extended coverage under one of the three reasons listed above, you can still continue health care benefits (at your expense) for up to 36 months under the federal COBRA law. **You must contact your local campus personnel office within 60 days or waive your rights to continuation of health care coverage under COBRA.**

Please sign and return both forms in the enclosed envelope as soon as possible. If this form is not received by October 15th, 2007, he or she will automatically be canceled from your coverage effective September 30th 2007.

X____
(employee signature)

Thank you for your prompt attention to this request.
Blue Cross Blue Shield of Alaska

PLEASE KEEP A COPY FOR YOUR RECORDS

MS 188
P.O. Box 327
Seattle, WA 98111

October 18, 2007

Please Return This Page To:
Blue Cross Blue Shield of Alaska
PO Box 327
Seattle, WA 98111-0327

VERIFICATION OF ENROLLMENT

STUDENT: «First_Name» «Last_Name»
ADDRESS: «Address_1»
«Address_2»**«City» «ST» «Zip»**

____
(student ssn)

____
(student signature)

EMPLOYEE: **«Sub_First_Name» «Sub_Last_Name»**
ID#: **«Sub_ID»**
GROUP#: **«Group_ID»**

*** TO BE FILLED OUT BY THE OFFICE OF THE REGISTRAR ***

The student identified above (is, was) enrolled as a (full-time, half-time, part-time) student **(circle one)**

for the quarter/semester of:

Fall_________________________________ (From MM/YY - MM/YY)

Winter_________________________________ (From MM/YY - MM/YY)

Spring_________________________________ (From MM/YY -MM/YY)

Summer_________________________________ (From MM/YY - MM/YY)

____
Signature of the Registrar

____
Date

____
College/University

____
Address

College/University Seal

____

____
Phone Number

If you are a student at the University of Alaska, you may be able to download enrollment information from UAOnline for no charge. If not, the student should go to the National Student Clearinghouse at www.studentclearinghouse.org and print off their enrollment documentation. A fee applies to this service.

The student verification form is also on the University of Alaska web site at www.alaska.edu/hr/forms/hr_healthforms.xml

PLEASE KEEP A COPY FOR YOUR RECORDS