Office of Human Capital
Employee Benefits Team

(585) 262-8206 Fax (585) 295-2614
Benefits@rcsdk12.org

ROCHESTER CITY SCHOOL DISTRICT

STUDENT CERTIFICATION FORM

☑ **Excellus Dental**

Please return to: Employee Benefits with proof of enrollment (admission letter, schedule, etc.)

Employee ID #_____

Subscriber Name: _____ **Subscriber ID#:** _____

Address: _____

Employer: **Rochester City School District** **Group #:** _____

Dependent's Name: _____ **Birth Date:** _____

Dependent's SSN: _____

PLEASE CHECK ALL THAT APPLY BELOW. Your student must meet one of these requirements to be eligible for continued coverage.

_____ My dependent is a full time student and not eligible for coverage through his/her own employer.

College/University: _____ Location: _____

School Year: _____ Expected date of graduation: _____

Freshman _____ Sophomore _____Junior _____ Senior _____ Graduate _____

_____ My dependent is on an approved medical leave of absence from the above college.

Date leave of absence began: _____

Is your dependent employed? _____**Yes** _____**No**

If yes, name of employer: _____

I UNDERSTAND THAT ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON, FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRADULENT INSURANCE ACT. THIS IS A CRIME AND THE PERSON SHALL BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED $5,000 AND THE STATE VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

Subscriber's Signature: _____ **Date:** _____