

process has changed—please read carefully

**student recertification form
to be completed and returned by {return date}**

FCHP/FHLAC subscriber cert#: _____

I hereby certify that _____ / ____/____
student's name Social Security number date of birth

(Please check one)

Is currently a FULL-TIME STUDENT (age 19 or older and unmarried)

Accredited educational institution: _____

City/Town: _____ State: _____

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

Expected date of graduation: ____/____/____

Is no longer a full-time student

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 student status. To ensure accuracy, I permit FCHP, including FHLAC, to contact the educational institution and take any other steps it considers necessary to verify the accuracy of the information I provided. I understand that any misrepresentation in the information I have provided will permit terminating the dependent's membership at the discretion of FCHP, including FHLAC.

(Subscriber's signature)

(Date)

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

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

