

PART I – MEMBER INFORMATION	
DEPENDENT NAME	
DEPENDENT MEMBER ID	
DEPENDENT BIRTH DATE	
SUBSCRIBER NAME	
SUBSCRIBER SOCIAL SECURITY NUMBER	

PART II – DEPENDENT RELEASE – <i>I authorize the named school to release my enrollment status to Keystone Health Plan East.</i>	
DEPENDENT SIGNATURE	
SIGNATURE DATE	

PART III – STUDENT VERIFICATION – <i>To be completed by Registrar.</i>	
NAME OF SCHOOL	
CURRENT ENROLLMENT STATUS	
CURRENT TERM	
ATTEMPTED SEMESTER HOURS	
EXPECTED DATE OF COMPLETION	
IF GRADUATED, DATE DEGREE AWARDED	
REGISTRAR SIGNATURE (VALIDATE WITH SCHOOL STAMP)	
SIGNATURE DATE	

PART IV – HANDICAP VERIFICATION – <i>To be completed by Physician and Subscriber.</i>	
NATURE OF HANDICAP	
DATE HANDICAP INCURRED	
IS HANDICAP PERMANENT (YES OR NO)	
IF NO, FROM AND TO DATES	
PHYSICIAN’S SIGNATURE	
SIGNATURE DATE	
SUBSCRIBER’S SIGNATURE	
SIGNATURE DATE	

We verify the above information is correct to the best of our knowledge and that the above named dependent has a handicap.

Please return to:

**KEYSTONE HEALTH PLAN EAST
 ENROLLMENT DEPARTMENT
 PO BOX 8240
 PHILADELPHIA, PA 19101-8240**