



International Medical Group®
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DEPENDENT STUDENT CERTIFICATION

Group Name _____ Group# _____
 Insured's Name _____ Identification # _____
 Insured's Address _____

I certify that _____, my son/daughter who is _____ years of age, is enrolled and a full-time student in an institution of higher learning.

Dates of enrollment: From _____ to _____
month/day/year month/day/year

Institution: _____

Address of registration office: _____

Telephone # of registration office: _____

Student's Social Security, Passport, or License Number: _____

I certify that he/she is unmarried and is dependent upon me for support.
 I authorize the said institution to release any information regarding the enrollment status of my son/daughter.

Signature of Parent/ Date

Registrar Office/ Admissions Office Date (Seal)

This form is for verification of Enrollment Eligibility. International Medical Group, at its discretion, may require additional documentation, such as grade transcripts or a letter from the educational institution at the time of claim.