CareFirst BlueCross BlueShield

CareFirst BlueChoice

# Confirmation of Enrollment

Name of Student_____

In order to consider reinstating coverage for the above student under his/her parent's coverage, the following information is necessary:

Original Date of enrollment as a full-time student (month)_____ (day)_____ (year) _____

Date of expected graduation (month)_____ (year) _____

Has the above student been continuously enrolled as a full-time student at your institution?

(If no, please explain) Yes _____ No _____

_____

_____

_____

Verified by: _____ Name and address of School:

Title: _____ _____

Date: _____ _____

Student's Name: _____

Identification Number: _____

Please return this form to:

CareFirst BlueCross BlueShield/CareFirst BlueChoice, Inc.
Enrollment & Billing
10455 Mill Run Circle
Owings Mills, MD 21117
Mail Stop 02-330



CUT5802-1S (1/02)