



## STUDENT CERTIFICATION AFFIDAVIT

I hereby certify that \_\_\_\_\_  
(Student Name) (Social Security Number)

\_\_\_\_\_ is a full time student at  
(Date of Birth)

\_\_\_\_\_ (Accredited Educational Institution) \_\_\_\_\_ (Registrar office's phone number)

\_\_\_\_\_ (City/Town) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip)

Date the Semester begins \_\_\_\_ / \_\_\_\_ / \_\_\_\_

I hereby certify that information provided above is true and accurate. I further agree to inform Blue Cross Blue Shield of Massachusetts immediately of any changes in this information. I understand and agree that the above information will be used to determine whether my dependent is entitled to dependent student health care coverage. If I misrepresent or provide false or incomplete information, my membership may be terminated (including retroactively) at the discretion of Blue Cross and Blue Shield of Massachusetts and / or my employer.

I understand that this signed affidavit must be received by Blue Cross Blue Shield of Massachusetts before any coverage can become effective for my dependent.

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

\_\_\_\_\_  
(Print Subscriber's Name)

\_\_\_\_\_  
(Subscriber's Signature)

\_\_\_\_\_  
(BCBS MA ID # from ID Card)

002580849 DENTAL  
004039048 HMO MED  
\_\_\_\_\_  
(Group #)

Please return to:

Hampshire County Group Insurance Trust  
99 Main Street – Old Courthouse  
Northampton, MA 01060  
Fax (413) 587-0056