HealthPlus OF MICHIGAN
The Plus makes all the difference.

STUDENT CERTIFICATION FORM

Student certification must be completed each year for dependents covered as a student. This form requires an authorized signature from the Registrar's office.

Student Name: _____

HealthPlus Member ID#: _____

The above individual is enrolled as a:

☐ **Full-time student** ☐ **Part-time student** ☐ **Not enrolled**

With _____ credit hours at (school) _____,

as of the current semester/quarter beginning _____, 20 _____.

_____ _____

Signature of Authorized Representative of Registrar's Office Date

☐ **Medical leave of absence (requires physician certification letter)**

Date student last attended school: _____, 20 _____.

Please return this form to:

HealthPlus of Michigan
ATTN: Enrollment Department
PO Box 1700
Flint, MI 48501-1700