



MEDICAL MUTUAL OF OHIO.
Your healthcare partner since 1934

Group Number:
Dependent:

Dear Policyholder:

Medical Mutual is conducting the annual student recertification process. This process is conducted due to the policy provisions that you have with Medical Mutual and is done on an annual basis for all policyholders that have dependents that are classified as full-time students.

In order to continue coverage as a student, your dependent must be enrolled as a full-time student. We define full-time student status as 12 or more hours of undergraduate study or nine hours for graduate work.

The top portion of the student certification form, found on the back of this letter, is to be completed by the policyholder and the student dependent. The bottom portion is to be completed by an official of the college or university. Please return the form to our office in the envelope provided.

So we may continue processing claims for your student dependent, please complete the form and return it to our office in the envelope provided by October 1, 2009. If the form is not returned by October 1, 2009, we will cancel the dependent's coverage effective September 1, 2009.

If you have any questions regarding this letter or the enclosed form, please contact our Customer/Member Service department at the phone number indicated on the back of your Identification Card.

Sincerely,

Membership Services

STUDENT CERTIFICATION

Dear Valued Medical Mutual of Ohio Policyholder:

Medical Mutual must have verification of full-time student status to provide coverage for dependent students of policyholders. To improve and expedite service, both you and your dependent student must sign the completed form. In addition, the student must obtain a signed confirmation from the school in the section provided below. Once this form has been completed, please forward it to Medical Mutual's Membership department.

1. Policyholder's employer: _____ Group number: _____
2. Policyholder's name: _____ Identification number: _____
3. Student's name: _____
Address: _____
Number and Street City State ZIP
4. Student's birthday: _____ - _____ - _____ 5. Relationship to policyholder: _____
6. Student is: Single Married Divorced Separated
7. Is student employed? Yes No If yes, Full-time Part-time School vacation period only
Name and address of employer: _____
8. Is student covered under any other group medical insurance or pre-payment program? Yes No
If yes, identify the other insurance carrier: _____ Policy number: _____
Policyholder: _____
9. Full name and address of school in which student is enrolled: _____

I AUTHORIZE THE ABOVE NAMED SCHOOL TO VERIFY AND/OR RELEASE ANY INFORMATION NECESSARY TO CONFIRM MY FULL-TIME ATTENDANCE AT THE SCHOOL FOR THE PURPOSE OF ESTABLISHING MY STUDENT STATUS.

Signature of Student / _____
Date

I CERTIFY THAT THE DEPENDENT IS A FULL-TIME STUDENT AND THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND AUTHORIZE RELEASE OF ANY INFORMATION REQUESTED WITH RESPECT TO THIS CERTIFICATION.

Signature of Policyholder / _____
Date

- SCHOOL CONFIRMATION -

Please confirm whether the above-named student is enrolled at your institution by checking the appropriate item(s) below:

The individual identified above: is a full-time student is a part-time student

Signature of Registrar or Other School Official / _____
Date