

Mail To:

United Health Care
PO Box 1600
Kingston NY 12402-1600

RE: STUDENT VERIFICATION

Date: _____

Name of Enrollee: _____-

Alternate/Card ID _____

Dependent's Name: _____

Dependent's DOB: _____

SCHOOL: _____

ADDRESS: _____

PHONE# _____

My dependent is a full time student for the _____ SEMESTER
_____ year.

Signature of enrollee: _____