HEALTHCARE BUILT FOR YOU

Sanford Health Plan

STUDENT VERIFICATION FORM

TO BE COMPLETED BY THE SCHOOL'S REGISTRAR:

Student Name: ____

Student Social Security #: _______-_______-_________ Student Date of Birth: ____/____/____

☐ Check here if student has graduated from college and is no longer a full-time student. Enter **Date of Graduation:** ____/____ mm/yy

☐ Check here if student is currently enrolled; indicate by check mark whether student is enrolled

Full Time ☐ or **Part Time** ☐

Enter Semester Begin Date ____/____/____ **Semester End Date** ____/____/____

____
Name of School

____
Address of School

____
Name of Registrar

____ ______________________
Signature of Registrar Date

Please return the completed form to *Member Services Department, Sanford Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110.* Or, you may fax it to *(605) 328-6812*.

If you should have questions or need additional information regarding this matter, please feel free to contact the *Member Services Department at 1-800- 752-5863, or (605) 328-6800*. We appreciate your cooperation.