

Student Verification

PO Box 91110
Sioux Falls, SD 57109
(605) 328-6800 • (800) 752-5863
Fax: (605) 328-6812
sanfordhealthplan.com



Student information

Name (dependent): _____

ID Number or SSN: _____ Date of birth: _____

To be completed by the school's registrar:

Check here if student is currently enrolled. Indicate whether status is full time or part time;

Full Time # of Hours _____

Part Time # of Hours _____

Semester Begin Date ____/____/____ Semester End Date ____/____/____

Name of School Address of School City State Zip

Name of Registrar Signature of Registrar Date

If you have questions, call Customer Service at (800) 752-5863 | TTY: 711

Please return the completed form.

Mail: Sanford Health Plan

PO Box 91110

Sioux Falls, SD 57109-1110

E-mail: memberservices@sanfordhealth.org

Fax: (605) 328-6812

Michelle's Law notice for Iowa and South Dakota members

Federal law requires that we provide the following notice regarding Michelle's Law [Public Law 110-381]. Please note that changes in federal law may eliminate certain elements of Michelle's Law, and the Plan intends to provide continuing coverage of Eligible Dependents up to age twenty-six (26), irrespective of their student status, for Plan Years beginning on or after September 23, 2010.

A Dependent Child over twenty-six (26) years old, who is enrolled in and attending an accredited college, university, or trade or secondary school at least five (5) months each year will remain covered if the Dependent takes a medically necessary leave of absence from school or changes to part-time status. The leave of absence must:

1. Be medically necessary;
2. Commence while the child is suffering from a serious illness or injury; and
3. Cause the child to lose coverage under the Plan.

Dependent Children are only eligible as long as they are covered by their parent's health insurance policy prior to diagnosis.

Coverage will continue until the earlier of one year from the first day of the leave of absence or the date on which coverage would otherwise terminate because the child no longer meets the requirements to be an eligible Dependent (e.g., reaching the Plan's limiting age).

You must provide written certification to the Plan from the Dependent Child's treating physician, stating that the Dependent Child is suffering from a serious illness or injury, that the leave of absence is medically necessary, and the effective date of the leave. Please send this certification to Sanford Health Plan, PO Box 91110, Sioux Falls, SD, 57109.