Student Dependent Attendance Report

For Coverage Underwritten/Administered by:
Mutual of Omaha Insurance Company
Companion Life Insurance Company

For DentaBenefits Plans Only:
United Concordia Insurance Company of New York

This information is required to update our records on an annual basis.

Home Office Use Only:
Auditor No. ___________________________ Policy/Plan No.____________________________________ Claim No.________________________

To Be Completed by Employee (Answer All Questions):

1. Name of group ____ Group ID ____

   Employee name ____ Employee Soc. Sec. No. ______________________________

2. Student name and relation to employee___________________________________ Birth date _________________________________

3. Name, address, and phone number of school, college, or university____

   ____

4. **Identify Below Your Enrollment/Plans to Enroll for the Next 12 Months:**

   Academic Period:

Beginning Date	Ending Date	Number of Credit Hours or if vocational school Hours spent in daily attendance
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________

5. Starting date of prior term ______________________________ Date that term ended ______________________________________

6. Any breaks in attendance from beginning of school?____

7. Anticipated date of graduation ____

8. Is the student chiefly dependent upon you for support? ☐ Yes ☐ No
   If "Yes," is this student reported as a qualified exemption on your federal income taxes? ☐ Yes ☐ No

9. Is the student gainfully employed?________ If so, give name, address, and phone number of employer ______________________

   ____

10. How many hours does student work each week? ____

11. Does student's employment provide group insurance? ____

12. If group insurance, give name, address, and phone number of insurance company ____

    ____

13. I hereby certify the statements hereon are complete and accurate, and understand they will be used to help determine the eligibility of my dependent according to the provisions of the policy. Furthermore, I understand it is my responsibility to notify the Insurance Company of any change in the status of this dependent as relates to the above information.

    Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

____ ____

Insured's Signature Date

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