

WATERSTONE BENEFIT ADMINISTRATORS

Group Number: _____

Student Dependent Questionnaire

Return with class schedule documentation to:

**Waterstone Benefit Administrators
4013 NW Expressway, Suite 575
Oklahoma City, OK 73116
(Or fax to 405-440-8948)**

Name of Insured Person		Name of Dependent		Policy Number	
TO BE COMPLETED BY THE INSURED PERSON					
Has the dependent show above ever been married? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, give date and place of marriage.		Name of Spouse	
Is this dependent attending an accredited school or college and primarily dependent upon the insured employee for support and maintenance? <input type="checkbox"/> Yes <input type="checkbox"/> No				If yes, please furnish the following information.	
Name of School or College		Address of School or College		Student Number	
Number of Hours Carried Hours per <input type="checkbox"/> Quarter <input type="checkbox"/> Semester			Inclusive Dates of Attendance From _____ 19____ TO _____ 19____		
Has there been any interruption or break in attendance (include 'Summer Vacation')? <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, give inclusive dates during which dependent was not in attendance.		
Is any type of insurance coverage sponsored or provided through school or college? <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, give name and address of insurance company and policy number.		
Is this dependent employed (including "Part-Time" employment)? <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, please furnish the following information.		
Date Employed		Name of Employer		Address of Employer	
Union Local Number		Name of Union (if "none" exists, so state)		Address of Union	
Number of hours worked per week:			Gross salary before deductions: \$ _____ per: <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month		
Normal Working Hours: <input type="checkbox"/> Daily <input type="checkbox"/> Weekly S M T W Th F S Daily: _____ To: _____			Is this dependent eligible for group insurance under a policy arranged by or through this employer and/or union? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If the answer to the above question is "Yes", give name and address of insurance company and policy number:					
Does this dependent have any source of income from other than the insured employee or employment shown above? <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, give source and amount.		
Are you, your spouse, or the dependent shown above eligible to receive any benefits for this claim under any public program, services or prepayment plan, or any group or franchise plan (other than this policy or insurance shown above)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If the answer to the above question is "Yes", give name and address of insurance company and policy number.					
It is understood and agreed that it may be necessary to contact any institution or organization listed above to verify the facts as stated herein. I therefore authorize any school or college, insurance company, prepayment organization, employer or union to release any and all information which may be requested in support of this claim. A copy of this authorization shall be valid.					
Signature of Insured Employees				Date	