

Student Dependent Attendance Report



For Coverage Underwritten/Administered by:
Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company
Exclusive Healthcare, Inc.

For DentaBenefits Plans Only:
United Concordia Insurance Company
United Concordia Dental Corporation of Alabama
United Concordia Life and Health Insurance Company
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):

- Name of group _____ Group ID _____
Employee name _____ Employee Soc. Sec. No. _____
- Student name and relation to employee _____ Birth date _____
- 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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

- Starting date of prior term _____ Date that term ended _____
- Any breaks in attendance from beginning of school? _____
- Anticipated date of graduation _____
- 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
- Is the student gainfully employed? _____ If so, give name, address, and phone number of employer _____

- How many hours does student work each week? _____
- Does student's employment provide group insurance? _____
- 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.

Insured's Signature _____

Date _____