



Confirmation of Enrollment

Name of Student			
In order to consider reinstating coverage for the above student under his/her parent's coverage, the following information is necessary:			
Original Date of enrollment as a full-time	student (month)	(day)	(year)
Date of expected graduation (month)	(year)		
Has the above student been continuously of (If no, please explain) Yes No	enrolled as a full-time —	e student at your	
Verified by:	Name and address of School:		
Title:			
Date:			
Student's Name:		_	
Identification Number:		_	
Please return this form to:			
CareFirst BlueCross BlueShield	l/CareFirst BlueChoid	ce, Inc.	
840 First Street, NE			
Washington, DC 20065			
Attention: Account Implement	ation Department		
Mailstop 31			

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