CareFirst BlueCross BlueShield

CareFirst BlueChoice

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 enrolled as a full-time student at your institution? (If no, please explain) Yes _____ No _____

_____

_____

_____

Verified by: _____

Title: _____

Date: _____

Name and address of School:

_____

_____

Student's Name: _____

Identification Number: _____

Please return this form to:

CareFirst BlueCross BlueShield/CareFirst BlueChoice, Inc.
840 First Street, NE
Washington, DC 20065
Attention: Account Implementation Department
Mailstop 31