STATE OF NEW YORK

STUDENT VERIFICATION FORM – VISION CARE

DEPENDENT STUDENT: An unmarried child, who is a full time student, will be covered through age 24. *(Dependent must be considered a full-time student by the school attended.)*

TO BE COMPLETED FOR DEPENDENT STUDENTS AGES 19 THROUGH 24 WHO WILL BE USING THE PLAN. **Please return this form to EyeMed Vision Care via US postal mail, email, or fax at least 10 days before services will be requested.**

I certify that my dependent, _____, _____
(PRINTED NAME) (DATE OF BIRTH)

is unmarried, and is enrolled full-time in an accredited secondary or preparatory school or college. I agree to advise EyeMed Vision Care promptly of any changes in my child's dependent student status.

Name of School:_____ Location:_____

Semester starts:_____ Semester ends:_____

_____ _____
Enrollee's Printed Name **Enrollee's Social Security Number**

_____ _____
Enrollee's Signature **Date**

Please return form to EyeMed Vision Care via one of the following methods:

1. **Mail to:** **EyeMed Vision Care**
   Attn: Membership
   4000 Luxottica Place
   Mason, OH 45040
2. **Fax to the attention of "EyeMed Vision Care – Membership" at 513-492-3605.**
3. **Email Address: Enroll@eyemedvisioncare.com**

Any person who knowingly and with the intent to defraud any company or other person files a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent 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 claims for each such violation.

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