

CARL HUMMEL  
COMMISSIONER

**STUDENT DEPENDENT CERTIFICATION**

Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ UMR Identification Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Employer: Onondaga County or OCC Employment Status: Active or Retired

Dependent Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dependent Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**1.** Is the dependent currently attending College full-time? Yes No

**2.** What enrollment period/semester is this certification for? Beginning \_\_\_\_/\_\_\_\_/\_\_\_\_ - Ending \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This section is for High School Students Only**

**1.** Is the dependent currently attending High School full-time? Yes No

a. What is the anticipated graduation date? \_\_\_\_/\_\_\_\_/\_\_\_\_

b. After graduating from High School will the dependent be attending College? Yes No

c. If the dependent is no longer attending High School, please provide the date in which he/she stopped attending,

or became a part-time student: \_\_\_\_\_\_\_\_\_\_

**This section is for College Students Only**

**1.** Is the Dependent currently attending College as a full-time Student? Yes No

a. If yes, what is the name of the College/University the dependent is attending? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. What is the anticipated graduation date? \_\_\_\_/\_\_\_\_/\_\_\_\_

c. If no, please provide the date in which he/she stopped attending school or became a part-time student: \_\_\_\_\_\_\_\_

**2.** After graduation will the dependent be attending Graduate School? Yes | No

*I attest that the information shown above is true and complete. I agree to advise the County of Onondaga promptly of any changes in my child’s dependent student status. I understand that any misrepresentation in the information I have provided above will permit the Onondaga County Dental Plan to terminate the dependent’s membership and seek any other legal remedies available to the County of Onondaga.*

**Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employer Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Certified through: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**