NYSHIP
New York State Health Insurance Program

EyeMed
VISION CARE®

# NEW YORK STATE VISION PLAN

## 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.*