Santa Clara County Office of Education

STUDENT CERTIFICATION

DENTAL AND VISION COVERAGE

Required for all dependents 19 – 25 years of age

To be eligible, the dependent must be:

- Full-time student in an accredited institution (12 units)
- Dependent upon employee for support
- Unmarried
- Under 25 years of age

_______________________________________ ___________________________
Dependent Name PRINT Date of Birth

_______________________________________ ____
Social Security Number Student I.D. Number

_______________________________________ ____
School Name PRINT School Address City, State, Zip

(_____)_________________________ www.____
School Telephone # and Website

I certify that the dependent shown above meets all of the requirements for coverage on my account as a full-time student. I understand that dental and vision coverage for this dependent will terminate on the first day of the month following the date that any one of these requirements is no longer met.

____________________________________ XXX-XX-________________
Employee Name - PRINT SS# Last 4 Digits

_____________________________________ ______________ _________________________________
Employee Signature Date Telephone (Home, Cell or Work)

Return form to Human Resources, 1290 Ridder Park Drive, San Jose, CA, 95131 or fax or email to:

Employee Benefits Specialist	Last name beginning	Phone number	Fax number	email
Denise Sanders	A-G	(408) 453-6831	(408) 453-3660	denise_sanders@sccoe.org
Selma Murillo	H-O	(408) 453-4355	(408) 453-3658	Selma_murillo@sccoe.org.
Patty Tijerina	P-Z	(408) 453-6681	(408) 453-3659	patty_tijerina@sccoe.org