

FITZHARRIS & COMPANY, INC.

To Be Completed by Subscriber for Dependent Certification

First Name / Last Name of Student Social Security # Date of Birth

Dependent Marital Status (must be completed): Single Married

Attending: _____
 Name of College, Accredited Institute or Trade, etc.

Student Enrolled: Full Time Part Time Post Graduate

Credits: _____ (must be completed to validate)

**Please Note: Clock hours are calculated by every 48 hours = 3 credits **

School Semester _____
 Month Year

Anticipated Date of Graduation _____
 Month Year

To Be Completed by Parent

Subscribing Parent Name:	
Mailing Address:	
Subscribing Parent Employer:	
Subscribing Parent Social Security# (last 4 digits only)	# XXX - XX _____
Effective Date of Insurance:	

Date Signed by Subscriber (must be signed to be validated)

PLEASE RETURN THIS FORM TO:
Fitzharris & Company Inc.
PO Box 9182
Farmingdale, NY 11735
Phone: 516-777-4800 or Fax (516) 777-5777