DELTA DENTAL®

Full-time Student Dependent Certification Form

Your Delta Dental plan may provide coverage for overage dependents if they remain full-time students. Please contact your Benefits Administrator to determine if your dependent falls under the student age limitations determined by your group.

Dependent Name _____ Date of Birth _____

Is this dependent a full-time student? ☐ Yes ☐ No

Dependent Name _____ Date of Birth _____

Is this dependent a full-time student? ☐ Yes ☐ No

Dependent Name _____ Date of Birth _____

Is this dependent a full-time student? ☐ Yes ☐ No

By signing this form, you understand and agree that it is also your responsibility to notify Delta Dental of any change in the eligibility status of your child dependent(s).

I hereby certify that the information provided above is correct. I understand that any misrepresentation in the information I have provided above will permit Delta Dental to terminate the dependent's membership and seek any other legal remedies available to Delta Dental.

Subscriber Signature _____ Date _____

Subscriber Name _____ Date _____

Group Number _____ Subscriber ID _____
Located on ID Card

Mail the completed form to:

Enrollment Department
Delta Dental of Massachusetts
P.O. Box 2907
Milwaukee, WI 53201-2907

OR Fax to: 1-617-886-1293 (if faxing, please do not mail form)