Student Documentation Verification

Complete this form if your employer requires you to provide proof of your dependent child's full-time student status in order to maintain eligibility for dental benefits. Verification should be done annually.

Dependent student information:

Name:	Date of birth:
Semester: Spring or Fall:	Calendar year:

Member information:

Member name:	Member date of birth:
Member phone number:	Delta Dental ID number:
Delta Dental group number:	Delta Dental group name:

Secondary member information (Complete only if your dependent is also covered by Delta Dental of New Jersey/Delta Dental of Connecticut benefits under another person's plan):

Secondary member name:	Secondary member date of birth:
Secondary member phone number:	Secondary member Delta Dental ID number:
Secondary member Delta Dental group number:	Secondary member Delta Dental group name:

By signing this form, I attest that all information is complete and accurate to the best of my knowledge. I understand that any misrepresentation in the information I have provided above will permit Delta Dental of New Jersey/Delta Dental of Connecticut to terminate the dependent's coverage. If the above information should change, I will inform Delta Dental immediately.

Member's name (print):

Member's signature

Date

Once completed, please return to Delta Dental:

Mail:
Delta Dental of New Jersey
PO Box 16354
Little Rock, AR 72231

Fax:
973-285-4141

Questions?
Please call Customer Service at **800-452-9310**
Monday - Thursday: 8:00 a.m. to 6:30 p.m. ET
Friday: 8:00 a.m. to 5:00 p.m. ET

Delta Dental of New Jersey, Inc., Delta Dental of Connecticut, Inc.,
5/2023