



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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Name: _____	Date of Birth: _____
Is this dependent a full-time student?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Name: _____	Date of Birth: _____
Is this dependent a full-time student?	<input type="checkbox"/> Yes <input type="checkbox"/> 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
PO Box 9695
Boston, MA 02114-9695

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