DELTA DENTAL

Full-time Student Dependent Certification Form

Your Delta Dental plan provides coverage for overage dependents as long as they remain full-time students. **Please confirm full-time student status by providing the requested eligibility information for the dependent(s) that should be covered as full-time student(s).**

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

Failure to return a signed form to Delta Dental will affect your dependent(s) eligibility for coverage. 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

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)