DELTA DENTAL®

STUDENT CERTIFICATION

Employer/Group Name	Delta Dental Group Number	
Subscriber Name	Subscriber ID Number	
Street Address		
City	State	Zip Code
Name of Dependent	Student's Date of Birth	
Name of School Attending	Expected Graduation Year	

No additional documentation is required to certify student status.

Signature: _____ **Date:** _____

Please return this form to:

Delta Dental of Rhode Island
Attn: Enrollment Department
P.O. Box 1517
Providence, RI 02901-1517

Or by fax to:
401-752-6040