DELTA DENTAL®

RE: Dependent Student Documentation Required

Dear Member

In 60 days, your dependent child will reach the contract age limitation for coverage under this plan or their student verification will have expired. In order to continue coverage, we require verification that he/she is registered as a full-time student, attending an accredited college and taking at least 12 credits for the upcoming school year. Student verification is required each year prior to start of the fall semester.

Please provide updated documentation of full-time student status to us immediately. Please disregard this notice if the information has been recently submitted. All outstanding claims, if any, will be reprocessed upon receipt of this form and any other information requested. The dental office does not need to resubmit any claims.

Submitting verification to Delta Dental of New Jersey each year at this time will minimize the delay in the processing of any claims.

Please complete the attached from and return it either by fax to (973) 285-4141
Or by mail to:
Delta Dental of New Jersey
Attention: Customer Service Correspondence
P.O. Box 222
Parsippany, NJ 07054

DELTA DENTAL®

Delta Dental of New Jersey, Inc.
Student Document Verification Form
P.O. Box 222 * Parsippany * NJ * 07054
Phone: 1-800-452-9310 Fax: 973-285-4141

Dear Member,

Your dependent child has reached the age limitation requiring verification that he/she is registered as a full-time student, attending an accredited college and currently taking at least 12 credits.

All outstanding claims will be reprocessed upon receipt of this form and any other information requested. The dental office does not need to resubmit any claims.

This form is required to be filled out at the beginning of every Fall school term to minimize delay of processing any claims.

Return this form by fax to 973-285-4141, or mail to our Customer Service Department, Attention: Correspondence.

Members Name: _____ Members ID Number: _____
Members Date of Birth _____ Cobra Plan: (Yes or No) ☐ Yes ☐ No
Daytime phone number: _____ Delta Dental Assigned Group Number: _____
Employer Name: _____

Dependent's secondary coverage with Delta Dental of New Jersey, Inc (if applicable)

Members Name: _____ Members ID Number: _____
Members Date of Birth _____ Cobra Plan: (Yes or No) ☐ Yes ☐ No
Daytime phone number: _____ Delta Dental Assigned Group Number: _____
Employer Name: _____

Dependent Name: _____ Dependent Date of Birth _____
Dependent's Social Security Number: _____
Name of College: _____ Semester & Year: _____
Student ID Number: _____
Number of Credits: _____ College Phone Number: _____

By signing this form, I attest that all information is complete and accurate. I authorize Delta Dental of New Jersey, Inc. to contact the college for further verification if necessary. If the above information should change, I will inform Delta Dental of New Jersey, inc. immediately.

Member **OR** Dependent Signature

Member's Signature: _____ Date: _____

Print Name: _____ _____

Dependent's Signature: _____ Date: _____

Print Name: _____

CS/July 2010