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 form and return it either by fax to (973) 285-4141 or by mail to:
The Customer Service Department Attention: Correspondence.

Delta Dental of New Jersey, Inc.
Delta Dental Plaza
1639 Route 10
Parsippany, NJ 07054

Telephone: 973-285-4000
Claims Inquiries:800-452-9310
Fax:973-285-4140

DELTA DENTAL®

RE: Dependent:

Please complete and return this form either by fax to (973) 285-4141 or by mail to:
The Customer Service Department Attention: Correspondence.

(I) MEMBER INFORMATION

Member Name: _____Date of Birth: _____ / _____ / _____

Member ID# (this could be Member Social Security Number):_____

Daytime Phone Number: (_____) _____ - _____ Employer Name_____

Delta Dental Assigned Group Number: _____ - _____ Cobra Plan: Yes or No (circle one)

(II) SECONDARY COVERAGE WITH DELTA DENTAL OF NEW JERSEY (if applicable)

Member Name: _____Date of Birth: _____ / _____ / _____

Member Social Security Number: _____ - _____ - _____

Daytime Phone Number: (_____) _____ - _____ Employer Name_____

Delta Dental Assigned Group Number: _____ - _____ Cobra Plan: Yes or No (circle one)

(III) DEPENDENT INFORMATION:

Dependent Name: _____Date of Birth: _____ / _____ / _____

Dependent's Social Security Number: _____ - _____ - _____

Student Identification Number (if SSN not used): _____

Name of College: _____College Phone Number: (_____) _____ - _____

Undergraduate or Graduate Student: (circle one) Number of Credits: _____

Semester: Fall or Spring (circle one) Year: 20__ __

(IV) SIGNATURES

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

Primary Member's Name (Print) _____

Primary Member's Signature: _____Date: _____ / _____ / _____

Secondary Member's Name (Print) _____

Secondary Member's Signature: _____Date: _____ / _____ / _____

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