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

Dear Subscriber,

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.

Subscriber Name: ___________________________
Subscriber Date of Birth: ____________________
Daytime Phone Number: ____________________
Employer Name: ___________________________
Subscriber Social Security Number: ______________
Cobra Plan: Yes or No (Please circle one)
Delta Assigned Group Number: ___________________

Dependent's secondary coverage with Delta Dental Plan of New Jersey (if applicable):

Subscriber Name: ____________________________
Subscriber Date of Birth: _____________________
Employer Name: _____________________________
Subscriber Signature: ________________________
Subscriber Social Security Number: ______________
Cobra Plan: Yes or No (Please circle one)
Delta Assigned Group Number: ___________________

Dependent Name: _____________________________
Dependent Date Of Birth: _______________________
Dependent's Social Security No.: ______________
Name of College: _____________________________
Semester: Fall or Spring (circle one) 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 Plan of New Jersey to contact the college for further verification if necessary. If the above information should change, I will inform Delta Dental Plan of New Jersey immediately.

Subscriber **OR** Dependent Signature
Subscriber's Signature: _________________________ Date: _________________

Print Name: __________________________________

Dependent Signature: _________________________ Date: _________________

Print Name: __________________________________