

**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.

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

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

Subscriber Name: \_\_\_\_\_ Subscriber Social Security Number: \_\_\_\_\_  
Subscriber Date of Birth: \_\_\_\_\_ Cobra Plan: Yes or No (Please circle one)  
Employer Name: \_\_\_\_\_ Delta Assigned Group Number: \_\_\_\_\_  
Subscriber Signature: \_\_\_\_\_

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: \_\_\_\_\_