

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

**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. If you have submitted this information either on this form, through your employer or your child is no longer a student, please disregard this request.**

**Return this form by fax to (973) 285-4141 or mail to: The Customer Service Department  
Attention: Correspondence. Note: No additional documentation is required.**

---

Subscriber Name: \_\_\_\_\_ Subscriber Identification Number: \_\_\_\_\_  
Subscriber Date of Birth: \_\_\_\_\_ COBRA Plan: Yes or No (Please circle one)  
Daytime phone number: \_\_\_\_\_ Delta Dental Assigned Group Number: \_\_\_\_\_  
Employer Name: \_\_\_\_\_

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

Subscriber Name: \_\_\_\_\_ Subscriber Identification Number: \_\_\_\_\_  
Subscriber Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ COBRA Plan: Yes or No (Please circle one)  
Employer Name: \_\_\_\_\_ Delta Dental Assigned Group Number: \_\_\_\_\_

Dependent Name \_\_\_\_\_ Dependent Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Dependent's Social Security Number: \_\_\_\_\_  
Name of College: \_\_\_\_\_  
Student Identification Number: \_\_\_\_\_  
Semester: Fall or Spring (circle one) Year (i.e. 2007) \_\_\_\_\_  
Graduate Student: Fall or Spring (circle one) Year (i.e. 2007) \_\_\_\_\_  
Number of Credits for Semester \_\_\_\_\_ College Phone Number: \_\_\_\_\_

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.

\_\_\_\_\_  
Subscriber OR Dependent Signature:

\_\_\_\_\_  
Print Name

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date