



Full-time Student Dependent Certification Form

Your DentaQuest plan may provide coverage for overage dependents if they remain full-time students. Please contact your Benefits Administrator to determine if your dependent falls under the student age limitations determined by your group.

Dependent Name: _____	Date of Birth: _____
Is this dependent a full-time student?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Name: _____	Date of Birth: _____
Is this dependent a full-time student?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Name: _____	Date of Birth: _____
Is this dependent a full-time student?	<input type="checkbox"/> Yes <input type="checkbox"/> No

By signing this form, you understand and agree that it is also your responsibility to notify DentaQuest of any change in the eligibility status of your child dependent(s).

I hereby certify that the information provided above is correct. I understand that any misrepresentation in the information I have provided above will permit DentaQuest to terminate the dependent's membership and seek any other legal remedies available to DentaQuest.

_____ Subscriber Signature	_____ Date
_____ Subscriber Name	_____ Date
_____ Group Number	_____ Subscriber ID <i>Located on ID Card</i>

Mail the completed form to: Enrollment Department
DentaQuest
P.O. Box 9708
Boston, MA 02114-9708

OR Fax to: 617-886-1040 (if faxing, please do not mail form)