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STUDENT VERIFICATION FORM

In order to determine eligibility for your dependent, please complete the information below, attach validation from the school, and mail to Member Services at the above address within thirty (30) days. Thank you for your cooperation.

Dependent's Name: _____

Birth Date: _____

Age: _____

Name of School: _____

Address of School: _____

Street

City

State

Zip

Number of Credits
per Semester: _____

Session: _____ Spring _____ Fall

School Enrollment Date: _____

Expected Graduation Date: _____

I understand that I will have to resubmit this form each term as long as my dependent is eligible for DentaQuest coverage. I also understand that his/her protection under my family coverage will terminate on the last day of the calendar month in which he/she marries, ceases to be financially dependent, ceases to be a full-time student, or reaches the maximum age specified in my employer's group contract.

Employee's Name (print) & Social Security Number

Date

Employee's Signature

Employer Name