



Tel: 415.526.1401  
Cell: 415.385.2510  
Fax: 415.545.2928  
info@directdental.com

TO BE COMPLETED BY THE SUBSCRIBER

Employer Name

Subscriber Name

Subscriber Social Security #

Name of Student

Student Date of Birth

Name of School

Address

Phone

I confirm that the above named dependent is registered as a full-time student at as accredited educational institution for the \_\_\_/\_\_\_/\_\_\_ semester, which begins on \_\_\_/\_\_\_/\_\_\_ and ends \_\_\_/\_\_\_/\_\_\_.

I attest that the information shown above is true and complete. I understand that failure to complete this form may result in delayed, denied or termination of coverage for the above named dependent. I understand that Direct Dental Administrators reserves the right to request additional information as proof of the above-named dependent's full-time status.

Further, any person who knowingly and with intent to defraud an insurance company or other person files a statement or claim containing any materially false information concerning any material fact thereto, commits a fraudulent insurance act, which is a crime, and is also subject to a civil penalty.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_