



**Altus Dental
Student Certification Form**

Altus Dental Subscriber ID#: _____

I hereby certify that _____
student's name Social Security number date of birth

(Please check one)

Is currently a FULL-TIME STUDENT (age 19 or older and unmarried)

Accredited educational institution: _____

City/Town: _____ State: _____

Registrar's telephone number: _____ Date semester begins: ___/___/___

Expected date of graduation: ___/___/___

Is no longer a full-time student

I hereby certify that the information provided is true and accurate. I understand that I am obligated to notify the City of Worcester immediately if there is a change in my dependent's student status. To ensure accuracy, I permit the City of Worcester to contact the educational institution and take any other steps it considers necessary to verify the accuracy of the information I provided. I understand that any misrepresentation in the information I have provided will permit terminating the dependent's membership at the discretion of the City of Worcester.

(Subscriber's signature)

(Date)

Please return this completed and signed form by mail or fax to:

**City of Worcester
455 Main Street - Room 109
Worcester, MA 01608
(508) 799-1030
Fax (508) 799-1040**

The Patient Protection and Affordable Care Act (PPACA) does not apply to dental coverage. For continuation dental coverage after the age of 19, the dependent must be unmarried and a full-time student.