altus dental™
Altus Dental Insurance Company, Inc.

STUDENT CERTIFICATION FORM

Employer/Group Name	Altus Dental Group Number	
Subscriber Name	Subscriber ID Number	
Street Address		
City	State	Zip Code
Name of Dependent	Student's Date of Birth	
Name of School Attending	Expected Graduation Year	

No additional documentation is required to certify student status.

Signature: _____ **Date:** _____

Please return this form to:

Altus Dental
Attn: Enrollment Department
P.O. Box 1557
Providence, RI 02901-1557

Or by fax to:
401-457-7240