



Oxford Area School District

A Proud Tradition - A Bright Future

DELTA DENTAL STUDENT VERIFICATION FORM

FOR DEPENDENT CHILDREN 19 TO 25

Dependent's Name: _____ **Date of Birth:** _____

Employee's Name: _____

Social Security Number: _____ **Date of Birth:** _____

Group Number: _____

**The dependent named above
is a full-time student at:** _____

of Credits _____

Anticipated date of graduation: _____

Employee signature

Date