Alberta Health Services

Public Health Dental Clinics Program

Student Dental Insurance Plan Information

Dear Student Dental Plan Administrator

Student Name	Phone
Alberta Health Services Dental Program requires information about dental insurance coverage offered to this student. Please complete the following:	

1. Is this student eligible for the student dental plan *(if NO, please advance to # 5)* ☐ Yes ☐ No
2. Are dependents eligible for the student dental plan? *(if NO, please advance to #5)* ☐ Yes ☐ No
3. Is the student presently enrolled in the student dental plan? ☐ Yes ☐ No
   If yes, coverage period is ________________ *(yyyy/Mon/dd)* to ________________ *(yyyy/Mon/dd)*
4. Are dependents presently enrolled in the dental plan? ☐ Yes ☐ No
   If yes, coverage period is ________________ *(yyyy/Mon/dd)* to ________________ *(yyyy/Mon/dd)*
   If no, on what date can the dependents be enrolled on the student dental plan?
   ________________ *(yyyy/Mon/dd)* to ________________ *(yyyy/Mon/dd)*

Date *(yyyy-Mon-dd)*	Administrator's Name	Phone

Student Health and Dental Plan Office administrative stamp:

This form is void without the official stamp

Please return this letter to the student. Thank you for your cooperation. If you have any questions about this form, please call the Public Health Dental Clinics at 403.955.6888

For office use only	SMCHC	NE

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