



Eligibility Verification

I hereby certify that the number of eligible employees for dental coverage at

_____ is _____.

Name of Employer # of Eligible Employees

Name (please print): _____

Title: _____

Signature: _____

Please return completed form to:

Delta Dental of Michigan
Attn: Laura Vulcano
27500 Stansbury Blvd.
Farmington Hills, MI 48334