DELTA DENTAL

Delta Dental of Minnesota

Agent of Record Assignment

Delta Dental of Minnesota

TO BE COMPLETED BY THE BROKER:

Agency Name:	
Broker Name:	
Agency Address:	
Agency Phone:	
Tax ID Number:	
Group Name:	
Group Number:	
Effective Date:	
*The effective date of the Agent of Record change will be the first of the month following the date of the change request.	

TO BE COMPLETED BY THE GROUP ADMINISTRATOR:

"I hereby certify that the above named Agency/broker is to be named as Agent of Record for my group and is entitled to all commissions in return for services rendered on my behalf in regard to my contract. The certification replaces all others having an earlier signature date. I understand that if another Agency/Broker is currently servicing my account, my signature below REPLACES that Agency/Broker.	
Print Name:	
Signature:	
Date:	

PLEASE DIRECT THIS AGENT OF RECORD FORM TO:

☐ **Community-rated small group (SC) clients:** **Delta Dental Connect** **500 Washington Ave S, #2060** **Minneapolis, MN 55415** **deltadentalconnect@deltadentalmnadmin.org**	☐ **Individually-rated large group (LG) clients:** **Delta Dental of Minnesota** **Attn: Sales and Marketing** **500 Washington Ave S. #2060** **Minneapolis, MN 55415** **ddmnbroker@deltadentalmn.org**