



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: _____

SUBMIT TO:

Delta Dental Connect
730 South Broadway
Gilbert, MN 55741

deltadentalconnect@deltadentalmn.org

Fax: 651-406-5937