



Delta Dental of Minnesota Online Enrollment User Request Form

Please review the attached Obligations and Termination provisions. Submit one request form for each individual who will have access to Online Enrollment and/or Directory Download. Complete the Company Information and User Information sections. Save the document using your company name. Email the form to: Delta Dental Connect at deltadentalconnect@deltadentalmnadmin.org or fax to 1-651-406-5937. The User will be sent their Username and Password in an encrypted email.

Company Information	
Date:	Main Company Contact Name:
Company Name / Group Number:	Main Company Contact Email:
	Main Company Contact Telephone Number:
User Information (Person using the secured portion of the website.)	
User Name and Job Title: <hr/> User Telephone Number: <hr/> User Email Address: <hr/>	Select Option(s) Being Requested: <input type="checkbox"/> Provider Directory Download <input type="checkbox"/> Online Enrollment Inquiry Only – List Group and Subgroup Number(s) below* that User is authorized to view. <input type="checkbox"/> Online Enrollment Add/Change – List Group and Subgroup Number(s) below* that User is authorized to add/change. *Required for Online Enrollment Group Number(s) Subgroup Number(s)
Group Administrator Authorization	
Signature:	Date:
I authorize access to Online Enrollment records to the individual listed in the User Information section.	
Security Information To be completed by Delta Dental Connect	
Incomplete Form: <input type="checkbox"/> Yes <input type="checkbox"/> No	Plan Number:
Authorized: <input type="checkbox"/> Yes <input type="checkbox"/> No	Marketing Approval Initials and Date:
User Password Information - To be completed by Enrollment Department	
Username:	Applications: <input type="checkbox"/> Online Enrollment Inquiry Only <input type="checkbox"/> Online Enrollment Add/Change
Password:	
Completed By:	Date:
Notes:	

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OBLIGATIONS:

Recipient Party acknowledges the confidential nature of Provider or Enrollment Information and agrees that it shall:

- (a) not disclose Provider or Enrollment Information to any employees of Recipient Party who do not have a reasonable need for such information in order to accomplish the permitted use;
- (b) instruct all employees who have access to Provider or Enrollment Information of the necessity to maintain the confidentiality of such information and to comply with applicable confidentiality policies;
- (c) except as expressly allowed, not disclose, directly or indirectly, in whole or in part, to any third party any Provider Information without the prior written consent of Delta Dental of Minnesota;
- (d) neither make any copies, abstracts or summaries of Provider Information nor modify it in anyway, except that Recipient Party may rearrange or sort Provider Information and make non-substantive format changes;
- (e) cause appropriate proprietary rights and confidentiality notices, markings or legends to be placed upon Provider Information; and
- (f) maintain reasonable and customary procedures to ensure compliance with the terms of this Agreement.

In addition, Recipient Party agrees to comply with such security measures requested by Delta Dental of Minnesota with respect to disclosure of Provider Information, including but not limited to requirements that individuals accessing Provider or Enrollment Information utilize an identification username and password in doing so.

TERMINATION:

This Agreement shall continue in effect until terminated. Either party may terminate this Agreement at any time by giving written notice thereof to the other party at the address set forth above. Termination shall become effective within thirty (30) days following receipt of the notice or any later date stated in the notice.

The Recipient party's assumes all responsibility of changes to security and any potential impact due to failure to notify Delta Dental of Minnesota in a timely manner.