



Agent of Record Assignment

Delta Dental of Nebraska

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

ddconnect@deltadentalne.org

Fax: 866-280-8359