Agent of Record Assignment

Delta Dental of North Carolina

TO BE COMPLETED BY THE PRODUCER:

Agency Name: ______________________________

Producer 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/Producer 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/Producer is currently servicing my account, my signature below REPLACES that Agency/Producer."

Print Name: ______________________________

Signature: ______________________________

Date: ______________________________

SUBMIT TO:

Delta Dental Connect
730 South Broadway
Gilbert, MN 55741

dconnect@deltadentalnc.org

Fax: 877-203-1381