DELTA DENTAL

Delta Dental of Minnesota

Individual

Agent of Record Assignment

Delta Dental of Minnesota

TO BE COMPLETED BY THE BROKER:

Agency Name:	
Agency Tax ID#:	
Broker Name:	
Broker License #:	
Broker NPN #:	
Broker/Agency Email:	
Individual Name:	
Social Security or Policy Number:	
Effective Date of Change:	

*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 POLICY HOLDER:

"I hereby certify that the above named Agency/broker is to be named as Agent of Record for this policy 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:

Delta Dental of Minnesota
Attn: Commissions

500 Washington Ave S. #2060
Minneapolis, MN 55415

ddmnbroker@deltadentalmn.org