



Agent Portal Registration and Authorization

Delta Dental of Wisconsin’s website has a secured agent section where registered users can produce on-line quotes, access group-specific documents such as handbooks, SPDs and contracts, and enjoy other features not available to general users.

To sign up persons at your agency, please complete the information on this form. We will confirm each individual’s registration via e-mail and then that person will be able to go to our website, create their own username and password, and immediately begin using the services of our site.

Section 1: Agency Information

Agency Name: _____

Address: _____

City: _____

State: _____ ZIP: _____ Phone: _____

Section 2: Program Agreement

This DELTA DENTAL OF WISCONSIN Website Agent Connection Security Form and User Agreement (the “Agreement”) is entered into, as of the date of the last signature below, between Delta Dental of Wisconsin Inc. (referred to as “DELTA DENTAL OF WISCONSIN”), and the agency identified above.

1) DELTA DENTAL OF WISCONSIN appoints the persons identified in Section 3 (the “Authorized Users”), as nonexclusive users of the DELTA DENTAL OF WISCONSIN Information System (the “System”). Each Authorized User is authorized to access the designated DELTA DENTAL OF WISCONSIN website, by means of a secure user ID and password, to view and receive information from the Agent area of the website for only those agents associated with the agency named above.

2) The Agency agrees to notify DELTA DENTAL OF WISCONSIN within 10 days, and complete a new Agreement, if the Agency Principal is no longer with the agency or is no longer the primary contact person for the Agency.

3) The Agency Principal is responsible for notifying DELTA DENTAL OF WISCONSIN of any additions, deletions or other changes to the list of Authorized Users.

4) This signed Agreement, or any questions related to this Agreement, shall be mailed to the corporate DELTA DENTAL OF WISCONSIN Sales Office.

5) This Agreement may not be modified or changed orally. All modifications must be in writing and signed by DELTA DENTAL OF WISCONSIN and the Agency Principal.

6) The System contains sensitive, confidential, and proprietary health benefit plan and financial information and must be protected against unauthorized disclosure, release, modification or other action. By entering into this Agreement, the Authorized Users agree to treat information as confidential and to preserve its confidentiality in accordance with all applicable state and federal laws and with DELTA DENTAL OF WISCONSIN’s rules and procedures for the users of the System. The Authorized Users also understand and agree that information is subject to change, information does change, and that DELTA DENTAL OF WISCONSIN relies on information provided by other sources not within DELTA DENTAL OF WISCONSIN’s control. As a result, DELTA DENTAL OF WISCONSIN makes no warranty or guarantee concerning the accuracy or reliability of the information accessible on the DELTA DENTAL OF WISCONSIN web site or on any other websites to which the DELTA DENTAL OF WISCONSIN website is linked.

7) The Authorized Users understand and agree that information obtained from the System does not guarantee payment of benefits by DELTA DENTAL OF WISCONSIN, or that any treatment, service, or supply provided to any patient is covered by DELTA DENTAL OF WISCONSIN. The Authorized Users further understand and agree that DELTA DENTAL OF WISCONSIN’s claim processing decisions about payment can only be made by DELTA DENTAL OF WISCONSIN when all necessary claim information is received and reviewed by DELTA DENTAL OF WISCONSIN in accordance with all terms, conditions, and provisions, including, but not limited to, exclusions of the applicable benefit plans.

8) The Agency shall defend, indemnify and hold DELTA DENTAL OF WISCONSIN and its employees, officers and directors harmless from all losses, claims, demands, damages, liabilities, or expenses, including attorneys’ fees and expenses, resulting from a violation of this Agreement due in whole or in part to acts of any Authorized User or Agency Principal.

9) By executing this Agreement below, the Authorized Users agree to all terms and conditions of this Agreement. If these terms and conditions are violated, DELTA DENTAL OF WISCONSIN may revoke the access rights of any Authorized User, without advance notice.

10) The Principal, Agent, and authorized users shall obtain and maintain for the duration of the Agreement errors and omissions liability insurance with minimum policy limits of one million dollars as covered thorough an individual or agency levels of coverage. Principal/Agent will notify the Delta Dental of Wisconsin immediately in the event of cancellation of such insurance and will request Principal/Agent’s errors and omissions liability insurer to notify Delta Dental of Wisconsin of any cancellation of Principal/Agent’s errors and omissions policy to Delta Dental of Wisconsin upon request. Principal/Agent will provide a copy of the face sheet from the errors and omissions policy to Delta Dental of Wisconsin upon request.

11) By executing this Agreement below, the Agency Principal represents that he/she has authority to act on behalf of the Agency and agrees to the terms above.

Agency Principal Name

Agency Principal E-mail

Agency Principal Signature

Date

Use Section 3 of this form to provide information about persons you wish to have access to online quoting via Instant Quote. Use Section 4 to register users for access to Group Documents.

Section 3: Instant Quote Registration and Authorization (attach additional copies if more space is needed)

Instant Quote provides online quotes in minutes for dental groups with 2-49 lives and vision groups of 2-499 lives. You do not need to be a licensed agent to be registered to use the site. However, only licensed agents can generate quotes on their own behalf. Unlicensed users can only produce quotes on behalf of other licensed agents.

Type of Request (choose one): _____

Name: _____

E-mail address: _____

Social Security Number: _____

Level of authority (choose one): _____

License number* : _____

Type of Request (choose one): _____

Name: _____

E-mail address: _____

Social Security Number: _____

Level of authority (choose one): _____

License number* : _____

Type of Request (choose one): _____

Name: _____

E-mail address: _____

Social Security Number: _____

Level of authority (choose one): _____

License number* : _____

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Name: _____

E-mail address: _____

Social Security Number: _____

Level of authority (choose one): _____

License number* : _____

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Name: _____

E-mail address: _____

Social Security Number: _____

Level of authority (choose one): _____

License number* : _____

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Name: _____

E-mail address: _____

Social Security Number: _____

Level of authority (choose one): _____

License number* : _____

Type of Request (choose one): _____

Name: _____

E-mail address: _____

Social Security Number: _____

Level of authority (choose one): _____

License number* : _____

Type of Request (choose one): _____

Name: _____

E-mail address: _____

Social Security Number: _____

Level of authority (choose one): _____

License number* : _____

* License numbers are required for individuals who will quote on behalf of themselves. The license number is optional for users who will only quote for others.

Send completed form to:
Delta Dental of Wisconsin
P.O. Box 828
Stevens Point, WI 54481
Fax: 715-343-7623

Section 4: Group Documents Registration and Authorization (attach additional copies if more space is needed)

Group Documents Registration enables users to access contracts, SPDs, handbooks, cost management reports, renewal reports and other group-specific information. You must be identified as the Agent of Record to have primary authority for accessing Group Document. Agencies may designate other individuals to have access to Group Documents for each Agent of Record.

*Authorized Individual***Name:** _____**License number:** _____**E-mail address:** _____**Social Security Number:** _____

Agents for whom the above person is authorized to access Group Documents

Name: _____**License number* :** _____**Name:** _____**License number* :** _____**Name:** _____**License number* :** _____**Name:** _____**License number* :** _____**Name:** _____**License number* :** _____**Name:** _____**License number* :** _____**Name:** _____**License number* :** _____*Authorized Individual #2***Name:** _____**License number:** _____**E-mail address:** _____**Social Security Number:** _____

Agents for whom the above person is authorized to access Group Documents

Name: _____**License number* :** _____**Name:** _____**License number* :** _____**Name:** _____**License number* :** _____**Name:** _____**License number* :** _____**Name:** _____**License number* :** _____**Name:** _____**License number* :** _____**Name:** _____**License number* :** _____

* License numbers are required if the individual being authorized is a licensed agent.

Send completed form to:**Delta Dental of Wisconsin
P.O. Box 828
Stevens Point, WI 54481
Fax: 715-343-7623**