PLAN SPONSOR'S CERTIFICATION CONCERNING AUTHORIZATION FOR IT TO REQUEST AND/OR RECEIVE PROTECTED HEALTH INFORMATION FOR PLAN ADMINISTRATION ACTIVITIES (LIMITED TO ENROLLMENT OR SUMMARY HEALTH INFORMATION)

TO: Delta Dental of New Jersey, Inc.
Delta Dental Insurance Company
Flagship Dental Plans
("You")

Re: Group Sponsor Name _____
Group Dental Plan Name _____
Group Dental Plan Number(s) _____ Sub-locations_____

1. The above named Sponsor of the dental benefit coverage which You provide for the Group Dental Plan has authorized me to sign this document on its behalf.
2. I hereby certify that the following are accurate statements:

A. The Sponsor has taken all steps necessary to comply with the Privacy Rule, 45 Code of Federal Regulations § 164 (if applicable) and all other applicable laws in order to give You this authorization.

B. The following individual(s) and/or job titles are duly authorized to identify to You those persons or entities whom the Sponsor has authorized to receive protected health information on its behalf (These persons have the Sponsor's authorization to inform You as to who should be able to access and/or receive PHI):

Name	Street Address / Email Address	Title
	Address:	
	Email:	

Sponsor: _____

Group Dental Plan Name _____

Group Dental Plan Number(s) _____Sub-locations_____

C. The following individual(s) and/or job titles are duly authorized to receive protected health information (as defined in the Privacy Rule) from You. The persons named will be able access and receive the following PHI:

VDE = View Dental Enrollment/Dis-Erollment/Participation Status (check if applicable)

SHI = Summary Health Information (as defined in 45 Code of Federal Regulations § 164.504(a) (check if applicable)

The following individual(s) and/or job titles are duly authorized to add, modify and/or delete enrollment information (i.e. electronic data files, on-line enrollment, etc.) on behalf of the Group Dental Plan:

MOD = Modify and/or delete enrollment information (check if applicable)

PASS = online password request enrollment information (check if applicable)

Name PLEASE PRINT	Company/ Title or Role	Address	Telephone & Fax#	VDE	SHI	MOD	PASS
		Address:	Tel #				
		Email:	Fax#				
		Address:	Tel #				
		Email:	Fax#				
		Address:	Tel #				
		Email:	Fax#				

Sponsor: _____

Group Dental Plan Name _____

Group Dental Plan Number(s) _____Sub-locations_____

3. The Sponsor agrees that it will request summary health information from You for only two purposes: (a) for use in obtaining premium bids and/or (b) for consideration in modifying, amending, or terminating the dental plan coverage.

4. The Sponsor agrees that it will limit its access or request protected health information from You to purposes permitted by the Privacy Rule and shall do so consistent with all applicable law.

5. The Sponsor authorizes You to rely upon this certification until you have received written notice that it has been revoked or rescinded. Such notice can be sent by first class mail or emailed to:

Mailing Address
Delta Dental of New Jersey, Inc.
Attn: U&A/Client Support
1639 Route 10, 3rd Floor
Parsippany, NJ 07054

Email Address
PHIForms@deltadentalnj.com

(Plan Sponsor's Name)

By: _____
(Signature – please use blue ink)

Print Name: _____

Title: _____

Effective Date: _____