DELTA DENTAL

ONLINE PASSWORD REQUEST

Please complete the below information for the Benefit Administrator who is requesting an online password. (Please print clearly) ***required information***

***Name**_____

***Phone #** _____

***Email address** _____

Fax # _____

Group Name_____

Group Number_____

***Sublocation(s) you are authorized to administer:**

_____

***Please complete the following:**

Are you replacing a previous Benefit Administrator who is no longer there? _____

If yes, name of person being replaced_____

Signature:_____

Date of request:_____

For completed forms:

- Send completed request forms to the Enrollment department at fax: 973-285-4142 or eliginquiry@deltadentalnj.com
- Please note: a current HIPAA authorization form must be on file before request can be completed
- You will be contacted by phone with your user name and login information