Authorization for Eligibility/Enrollment/ Enrollment Web Portal Access (PHI Form)

I, _______________________, am authorized on behalf of ____ [insert name of Group and DDNJ/DDCT assigned group number] to identify the individuals listed below as authorized to receive a username and password to access the Delta Dental eligibility and enrollment portal and access to information regarding eligibility and enrollment.

I understand that eligibility and enrollment information and reports as well as access to the enrollment web portal contain information subject to federal and state privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA), and contain information such as the names, home addresses, dates of birth, and social security numbers of individuals and dependents enrolled in the benefits plan (Enrollment Data).

I understand that a person can have different roles when they access Enrollment Data and the web portal. These roles include the following:

- **View** – allows a person access to view and receive enrollment reports or information. (no password to access web portal).
- **Modify** – allows a person to view and receive enrollment reports or information; and allows a person to add and delete eligibility; also allows a person to modify enrolled employee and dependent information, such as address for our group benefit plan (no password to access web portal).
- **Password** (includes View and Modify through the web portal) – allows a person to obtain a password to access the web portal to view and modify Enrollment Data.

Each of the individual(s) whose names appear below are authorized for the following access and roles:

Name and Address	Email Address	Phone Number	View (Y or N)	Modify (Y or N)	Password (Y or N)

Delta Dental shall be entitled to rely on any additions, deletions, or modifications to the Enrollment Data entered by an authorized individual listed above.

I understand that each of the individuals listed above will have access to Enrollment Data that is the subject of federal and state privacy, security, and data breach laws and that each understands that their access, use, and disclosure of this information shall be limited to an authorized business purpose related to administration of the benefits plan provided by Delta Dental.

I understand that I have an ongoing responsibility to provide Delta Dental with prompt written notice if any individual listed above no longer has permission to view or modify Enrollment Data or to have a username and password to the Enrollment Web Portal. I agree to provide written notice to the email address listed below to allow Delta Dental to disable the user account of any person no longer authorized to access the Enrollment Data or the Delta Dental enrollment portal.

Print Name________________________________

Signature_________________________________

Title_____________________________________

Email____________________________________

Telephone Number__________________________

<u>Mailing and Email Address</u>
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