Employer Toolkit Access Request

CLIENT INFORMATION

Client name: ____ Client number: ________________________________

Sub-client(s): ❑ All OR ❑ Specific Locations: ____

AUTHORIZED USER INFORMATION

Please provide information for the person requiring access. If multiple users are required, complete a form for each person.

Authorized user's name / email: _______________________________ / _____________________________________
User ID & passwords will be emailed separately to this address.

Eligibility Access Options (select 1): ❑ View Only OR ❑ View and update

Are you an AGENT with authorized access to the Delta Dental Employer Toolkit? ❑ Yes ❑ No

If yes, list your user name: ____

ONLINE BILLING (This section must be completed if online billing is being requested.)

Once online billing is activated, paper bills will be turned off and bills can be accessed via the Delta Dental Employer Toolkit.

Online Billing Access Options (select 1): ❑ View Bill Only ❑ View & Adjust Bill ❑ View, Adjust, & Finalize Bill

On behalf of ____, and with authority to act on behalf of this group, I understand and consent to the following:

1. The group's monthly bill will be posted electronically to the DDAR website. It is the group's responsibility to retrieve the bill from the website.
2. The only bill the group will receive will be the electronic bill.
3. The group is responsible for paying the bill no later than the 1st day of every month.
4. The group must inform DDAR of any changes to its authorized user's email address, so DDAR can send the group notices regarding its bills. The group is still responsible for timely payment of its bill, regardless of such notices.

TERMS AND CONDITIONS OF USE

Delta Dental of Arkansas (Delta Dental) permits Groups to open Website Accounts for Authorized Individuals for purposes of submitting timely, accurate and complete Group enrollment data to Delta Dental on the Group's behalf. The Group, acting through its undersigned representative, certifies that the users identified in this application are authorized to submit enrollment data to Delta Dental on the Group's behalf and, in consideration for Delta Dental's grant of access via this Website Account, agrees to the following conditions: (1) Delta Dental may rely on this electronically submitted enrollment data to the same extent as if submitted by non-electronic means; (2) Group will undertake reasonable measures to safeguard account information, including username and password, and to prevent unauthorized access to the Website by someone acting or purporting to act on the Group's behalf; (3) All requests to close the Website Account must be submitted in writing to Delta Dental via fax to 501-992-1899, Delta Dental shall have three business days (excluding holidays) to close the Website Account; (4) Group shall be solely responsible for any liability arising from the use of the Website Account and shall indemnify, hold harmless and defend Delta Dental against any claim arising from the Authorized User's use of the Website Account or the Group's failure to safeguard account information, including, but not limited to, errors and omissions and violations of state and federal privacy laws; and (5) the individual signing this application has the authority to permit the requested access and bind the Group to the terms and conditions set forth above.

Group Administrator Name: ____

Group Administrator Signature: ____

Date: ________________________________ Phone Number: ____________________________________

Once completed, please fax the form to your Delta Dental Account Manager at (501) 992-1899 or email at ARSalesSupport@deltadentalar.com. After we process your request, the request is processed, you will receive two emails, the first with your username, and the second with your password. Once your bill is ready, you will receive an email notification that your bill is available. If you have any questions regarding your bill, please contact your Billing Auditor for assistance.