DELTA DENTAL

Group Application for Online Resources

DELTA DENTAL OF OKLAHOMA

Group Name: _____

Group Number: _____

Please complete the following information for each contact to provide and/or change Online Resources access.

Contact Name: First and last name of the contact to receive online access.
Subgroup(s) Access: Contact(s) will receive access to the specified subgroup(s). Please enter 'ALL' if a contact should have access to all subgroups.
Online Eligibility: Contact(s) will receive online access to *view or modify* eligibility for the specified subgroup(s).
View Only: Read-only access to online eligibility.
Modify: Ability to make eligibility changes online.
E-Bill: Contact(s) will receive invoice notifications via email and online access to invoices and bank/credit card payments.
Email Address: A valid email address is required for each contact.

Contact Name	Subgroup(s) Access	Online Eligibility (Select One)		E-Bill	Email Address (Required)
		View Only	Modify		

I _____, an authorized representative for _____, approve access to our account for the contact(s) named above. I understand that it is the responsibility of our company to submit written notification to Delta Dental of Oklahoma if a user's access to Online Resources needs to be terminated.[+] Through the selection of the above options, I agree my company will receive our monthly invoice from Delta Dental of Oklahoma via the above selected option only.

[+]A Group Change Form is available on Online Resources and completed forms may be submitted to ClientRelations@DeltaDentalOK.org by a current authorized contact for our company.

Signature: _____ Date: _____

Please submit the completed form to **ClientRelations@DeltaDentalOK.org**.