

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 Plan of New Jersey, Inc.
 Delta Dental Insurance Company
 Flagship Dental Plans
 (the "Delta Dental New Jersey Plan System")

Re: Group Dental Plan (hereinafter "the Group Dental Plan")
 (Name) _____
 (Number(s)) _____

_____ is the sponsor of the dental benefit coverage the Delta Dental New Jersey
 (Insert Group Dental Plan Name)
 Plan System provides for the Group Dental Plan. I am authorized by the Sponsor to certify and on its behalf
 hereby certify the following to you:

1. The Sponsor has taken all steps necessary to comply with the Privacy Rule, 45 Code of Federal Regulations § 164 (if applicable) and other applicable law in order to give you this authorization.
2. The following individual(s) and/or job titles are duly authorized to request from you:
 - Dental enrollment/dis-enrollment/participation status (check if applicable)
 - Summary health information (as defined in 45 Code of Federal Regulations § 164.504(a) (check if applicable))

<u>Name</u>	<u>Title</u>	<u>Telephone #</u>	<u>Fax #</u>

3. The following individual(s) and/or job titles are duly authorized to identify to you these persons or entities that the Sponsor has authorized to request on our behalf:
 - Dental enrollment/dis-enrollment/participation status (check if applicable)
 - Summary health information (as defined in 45 Code of Federal Regulations § 164.504(a) (check if applicable))

<u>Name</u>	<u>Address</u>	<u>Role (e.g. third party administrator, broker)</u>

4. The following individual(s) and/or job titles are duly authorized to receive protected health information (as defined in the Privacy Rule) from you:

<u>Name</u>	<u>Title</u>	<u>Telephone #</u>	<u>Fax #</u>

5. The following individual(s) and/or job titles are duly authorized to identify to you these persons or entities that the Sponsor has authorized to receive protected health information on our behalf:

<u>Name</u>	<u>Address</u>	<u>Role (e.g. third party administrator, broker)</u>

6. We 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.
7. You are authorized to rely upon this certification until you have received written notice that it has been revoked or rescinded.

(Plan Sponsor's Name)

By: _____
(Signature)

Print Name: _____

Title: _____