Delta Dental of Kentucky, Inc.
Dental Choice, Inc.

DELTA DENTAL®

Producer Data Sheet

Producer Name: _____ SSN: _____

Date of Birth: _____ KY DOI #: _____

Residence Phone: _____ NAIC NPN #: _____

Residence Address: _____
(Street) (City) (ST) (ZIP)

Business Physical Address: _____
(Street) (City) (ST) (ZIP)

Business Mailing Address: _____
(PO Box) (City) (ST) (ZIP)

Business Phone: _____ Business Fax: _____

E-mail Address: _____

I am interested in representing DDKY for: ❑ Group Plans ❑ Individual/Family Policies ❑ kynect (KY Exchange)*
**Send copy of kynect certification*

ASSIGNMENT OF COMMISSIONS

If commissions are to be paid to an agency, please complete the information below and include a W-9 for the agency.

Agency Name: _____

Agency Tax ID #: _____ Agency KY DOI #: _____

I, _____ , do hereby request that any and all commissions due and owing to me from Delta Dental of Kentucky be paid to the above agency.

Signature of Applicant: Date: _____

IMPORTANT NOTICE TO APPLICANT:

Designated producers must comply with all the regulations of Delta Dental of Kentucky, Inc. In compliance with Section 91-508 of the Fair Credit Reporting Act, Delta Dental may run a routine inspection to provide information concerning Producer's general reputation, personal characteristics and mode of living in connection with application to act as one of its representatives. This report may be obtained through the Kentucky Office of Insurance (KOI), business associates, financial resources, family members, friends, neighbors or others with whom Producer is associated.

DDKY USE ONLY:

EFFECTIVE DATE: _____

RECREDENTIALED: _____
(Date) (Date) (Date) (Date)

TERMINATION DATE: _____

DOI NOTIFIED: _____ AGENT/AGENCY NOTIFIED: _____

❑ ETS ❑ KYNECT ❑ VENDOR FILE ❑ ASSIGNED REP