

## Agent of Record Change Request For Dental Blue Select<sup>SM</sup>

FOR GROUPS ALREADY ENROLLED WITH Blue Cross and Blue Shield of  
North Carolina (BCBSNC)  
To be accepted ONLY on the group's letterhead

**Copies of this letter must be sent or faxed to BCBSNC at both addresses below:**

April 8, 2008

BCBSNC  
Attention: Producer Operations  
P.O. Box 2291  
Durham, NC 27702  
Fax: (919) 765-3334

BCBSNC  
Attention: Billing Department  
P.O. Box 2400  
Winston Salem, NC 27102  
Fax: (336) 714-1445

Re: Request to Change Agent of Record

This letter will serve to notify you that we hereby appoint:  
[Fill in Name of New Producer along with Agency Name] [P Number of New Producer]  
as our broker/agent Representative. We hereby authorize him or her to be our group's  
only representation for transactions necessary to negotiate dental insurance benefit  
plans for our existing group policy with Blue Cross and Blue Shield of North Carolina.

In addition, we hereby rescind our appointment of [Fill in Name of Previous Producer  
and Agency Name] as our broker/agent representative.

We understand this change will remove the current agent/broker for all purposes,  
including servicing capabilities. We also understand this change will terminate any  
further payments of commission to the current agent/broker.

**\*\*The effective date is always the first day of the month following the AOR  
request. It MUST NOT be less than 12 business days from the signature date.\*\***

I certify that I am an authorized official of this company and that all information contained  
herein is complete and accurate to the best of my knowledge.

\_\_\_\_\_  
[Group Name]

\_\_\_\_\_  
[Group Number]

\_\_\_\_\_  
[Print Name – Authorized Signer]

\_\_\_\_\_  
[Signature – Authorized Signer]

\_\_\_\_\_  
[Title]

\_\_\_\_\_  
[Date]