



Health Insurance Associates Inc.

Agent of Record Form

Enrollee Information

Member Number (if available): _____

Name: _____

Mailing Address: _____

Phone #: _____ Email Address: _____

Please appoint _____ as my agent of record effective through _____ (date). I understand that the named agent will represent my coverage through _____ (carrier), and that this agent will receive commissions on my coverage. If I have a current agent of record, I wish the undersigned agent to be appointment as a replacement.

Member Signature: _____ Date: _____

Agent Information

I accept the assignment of the above-named person as his or her agent of record. By signing below, I agree that the information on this form is complete and accurate.

Original Servicing Agent Signature: _____ Date: _____

New Servicing Agent Signature: _____ Date: _____

Dan Howell's Signature: _____ Date: _____