PacificSource Community Health Plans

Medicare Advantage
Agent of Record Change Request

Subscriber Name:_____ Date _____

Policy Number: _____ Policy Effective Date: _____

Dear Medicare Sales Department:

I have appointed a new agent as exclusive insurance representative with respect to my Medicare Advantage plan provided by PacificSource. I understand that the new agent is not an employee of PacificSource.

I have authorized this agent to act on my behalf in place of my former agent.

This letter enables PacificSource to furnish my new agent with all information he or she may request as it pertains to my insurance contract. I understand that the agent's broker commission will be paid out of my monthly premiums.

This designation will remain in effect until I notify you otherwise, in writing.

Former Agent: _____

New Agent: _____

Agency: _____

Business Address: _____

Sincerely,

_____
Printed Name of Member

_____
Signature of Member

Please complete and sign this letter and return to PacificSource via:

- Email to medicareagentcoordinator@pacificsource.com
- Fax to 541-382-3407; or
- U.S. mail to PacificSource Community Health Plans, Inc., 2965 NE Conners Ave, Bend OR 97701