

BROKER OF RECORD AUTHORIZATION



If you wish to recognize a broker to represent your HealthAmerica/HealthAssurance coverage, please provide the following information.

To be completed by the broker:

Writing Agent: _____
Social Security Number: _____ - _____ - _____
Commission Payable To: _____
Tax ID: _____ - _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Telephone: _____

Your signature below as the **authorized company representative** allows the individual listed above to act as an agent of HealthAmerica/HealthAssurance and to receive compensation in the form of monthly commission payments for his/her services. The premium rates which will be quoted for your company will not be affected whether or not you elect to utilize the above broker. **You further understand and agree** that the broker does not have the authority to approve your coverage and/or effective date.

The broker of record listed above will remain in force continuously unless HealthAssurance receives formal notification of cancellation in writing from your company.

To be completed by authorized company representative:

Company Name: _____
Authorized Company Representative Name: _____
Authorized Company Representative Signature: _____
Authorized Company Representative Title: _____
Date: _____

To be completed by HealthAmerica/HealthAssurance Sales Department:

Group Number: _____ Effective Date: _____