Broker of Record Form

Attn: Broker Relations
500 Exchange Street
Providence, RI 02903
BrokerRelations@bcbsri.org

☐ Group Health
☐ Group Dental
☐ Stand Alone Vision
☐ Group Stop Loss

Effective Date: _____

Employer Group Name: _____

Employer Group Number(s): _____

To be completed by New Broker:
As the new Broker, I accept the assignment of the above named group as their Broker of Record. I further certify that all the information shown above is correct and complete to the best of my knowledge. I understand that any compensation arrangements will be disclosed separately from this form and that this group will be included in my book of business based on the effective date of the change.

Broker ID Number: _____ Agency ID Number:_____

Broker Name: _____ Agency Name: _____

Broker Signature: _____ Split %: _____

Broker ID Number: _____ Agency ID Number:_____

Broker Name: _____ Agency Name: _____

Broker Signature: _____ Split %: _____

To be completed by General Agent (If Applicable):

BCBSRI General Agent Number: _____

General Agent Name: _____

General Agent Signature: _____ Date: _____

To Be Completed by Employer Group:
I understand that this Broker of Record will take effect on the first of the month following the receipt of this form by BCBSRI. In addition, this Broker of Record will allow BCBSRI to release information to the named broker(s) regarding my account, including rates, enrollment and plan information. I am aware that this Broker of Record will replace any prior Temporary or Permanent Broker of Record. I attest that I have the authority to make this appointment. This appointment shall remain in force until terminated in writing.

Company Officer Name: _____

Title: _____

Signature: _____ Date: _____