



Agent of record

Enrollee Information

Group Name: _____

Group Number: _____

OR

Member Name: _____

Member Number (if available): _____

Mailing Address: _____

Phone #: _____ Email Address: _____

Please appoint _____ as my agent of record effective _____.

I understand that the named agent will represent my group or individual coverage through MHC, and that this agent will receive commissions on that coverage. If I have a current agent of record, I wish this agent to be appointed as a replacement.

Group Contact/Member Signature _____ Date _____

Agent Information

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

Name: _____ Insurance License #: _____ NPN: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____

Signature: _____ Date: _____

Return completed form to:

E-mail: agentinfo@mhc.coop

Or

Mail: Mountain Health Co-Op

PO Box 5358

Helena MT 59604