

Agent of Record Change Form

Policy Holder Information (All fields required)		
Policyholder Printed Name:	Policy Holder Providence ID:	Date of Birth:

New Agent Information (All fields required)	
Agent's Printed Name:	Agent National Producer Number (NPN):
Email:	Phone:

Reason for AOR (Required):

This is a request to assign the above-named agent as the Agent of Record for the policyholder named above. This appointment removes any prior agent and is continuous until another agent is designated by the policyholder.

Signatures (All fields required)	
Policyholder Signature:	Date:
Agent Signature:	Date:

Please email your completed AOR Form to:

AgtCoordinatorUnit@providence.org

Subject: AOR Request

Important Notes

Medicare Advantage & Medicare Supplement

- If member is in their Initial year of enrollment per CMS or New to PHA, the effective date of the AOR change effective the first of the month following the member signed the AOR. However, agent commission is not effective until the first day of the following calendar year.
- If member is a renewing member with Providence, the effective date of the AOR change will be effective the first of the month following the date the member signed the AOR.

Individual & Family

- The AOR change will be effective the first of the month following the date the member signed the AOR form.