

Broker of Record

Effective Date:

| | | |
|--|------------------------|--------------------------|
| Blue Cross and Blue Shield of Rhode Island | BCBSRI Group Health | <input type="checkbox"/> |
| Attn: Broker Relations | BCBSRI Group Dental | <input type="checkbox"/> |
| 500 Exchange Street | BCBSRI Group Stop Loss | <input type="checkbox"/> |
| Providence, RI 02903 | | |

Group Number(s): _____

Group Name: _____

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. If an account was considered as new business and was assigned a broker, the original broker is entitled to receive commission for the remaining 12 months or until the group's first renewal.

BCBSRI Broker ID Number: _____ %:

Broker Name: _____ Agency Name: _____

Broker Signature: _____ Date: _____

BCBSRI Broker ID Number: _____ %:

Broker Name: _____ Agency Name: _____

Broker Signature: _____ Date: _____

To be completed by General Agent (If applicable):

BCBSRI General Agent Number: _____

General Agent Name: _____

General Agent Signature: _____

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 terminate any prior Temporary or Permanent Broker of Records. This appointment shall remain in force until terminated in writing.

Company Officer Name: _____

Title: _____

Signature: _____ Date: _____