Broker of Record

Effective Date:

Blue Cross and Blue Shield of Rhode Island
BrokerRelations@bcbsri.org
Attn: Broker Relations
500 Exchange Street
Providence, RI 02903

BCBSRI Group Health ☐
BCBSRI Group Dental ☐
BCBSRI Group Vision ☐
BCBSRI Group Stop Loss ☐

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.

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:	Date:

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: