



## 2015-2016 Individual Plan Agent of Record Designation Form

The purpose of the Agent Designation Form is to provide notice to a participating insurance company of a MNSure member's/applicant's interest in designating an agent as that member's/applicant's "agent of record". It is understood that under this designation:

1. The Agent identified must have a license in good standing with the State of Minnesota, and has completed all requirements to be a certified agent with MNSure.
2. The Agent has an active appointment with the insurance company that issued the insured's policy.
3. The appointed Agent will be authorized on the date of signature below, to carrier information about the insured and the policy.

**The Agent/Broker and member/applicant must fully complete and sign this form. The Agent is to forward a copy to the MNSure at the address or fax number listed below.**

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### Agent Information

Agent Full Name

Agency

Agent National Producer #

Address

City

State

Zip code

Agent Phone #

Email

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### Applicant Information

Applicant Full Name

DOB

Applicant Address

City

State

Zip code

Applicant Phone #

Email

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### Qualified Medical Plan Details

**Reason for Sending AOR Designation Form:**

New Application

Retroactive

Renewal

Other: (please provide reason

Plan Change

Health Carrier

Plan Name

Coverage Effective Date

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## Qualified Dental Plan Details

### Reason for Sending AOR Designation Form:

New Application

Retroactive

Renewal

Other: (please provide reason)

Plan Change

Dental Carrier

Plan Name

Coverage Effective Date

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## Signatures

### Applicant's Signature

*I attest that the above named agent has assisted me in the MNSure application and enrollment process as of or prior to the Plan Coverage Effective Date. I understand that the named agent will receive commissions or service fees beginning on the Plan Coverage Effective Date listed above until termination of the policy or until another agent is named in their place, effective upon the next premium cycle.*

Applicant Signature

Date

### Agent's Signature

*I attest that I am certified with MNSure as of the plan coverage date listed for the consumer on this form and therefore authorized to sell and assist the consumer named above on the Marketplace.*

Agent Signature

Date

**NOTE TO AGENTS:** This form has been approved by Carriers offering qualified health plans through MNSure. MNSure related Agent of Record Designations must be submitted on this form. Carriers have approved the use of this form for the purpose of identifying Agent of Record Designations for MNSure enrollees only. This form does not affect an Agent's Carrier/Broker agreement or terms thereof, nor does it replace any Carrier form for non-MNSure related clients, or terms of compensation.

### Please forward completed form to:

MNSure  
81 E 7th Street, Suite 300  
St. Paul, MN 55101

Or fax to 651-431-7435