LOUISIANA HEALTH COOPERATIVE

Agent of Record Letter (AOR)

I. Request Information

Request Type:

- ☐ New *(If this is a New Request, fill out Sections I, II and IV)*
- ☐ Change *(If this is a Change to an already existing AOR, fill out Sections I, II and IV)*
- ☐ Termination *(If this is a Termination to an Existing AOR, fill out Sections I, II, III and IV)*

Request Date
Effective Date of Initiation, Change or Termination

II. Member Information

Full Name: _____ Member ID #: _____
(Last Name) (First Name) (Middle Initial)

Street _____

City _____ State ____ Zip _____ Parish _____

Phone: _____

III. New Agent/Broker Information

Name of Agency/Broker: _____

Street _____

City _____ State ____ Zip _____ Parish _____

Phone: _____ NPN _____

IV. Old Agent/Broker Information

Name of Agency/Broker: _____

Street _____

City _____ State ____ Zip _____ Parish _____

Phone: _____ NPN _____

V. Statement of Agreement

This letter/form gives the above Agency/Producer, specified in Section III, exclusive rights to the use of Louisiana Health Cooperative (LAHC) products and services on my behalf.

This letter also replaces any and all previous Agent of Record (AOR) documents, if applicable, and terminates the rights of any other Agency/Producer to service my insurance needs.

Date: _____ Signature: _____

Completed and signed Agent of Record Letter (AOR) should be submitted to:

Louisiana Health Cooperative
Sales & Marketing Coordinator
3445 North Causeway Blvd.
Suite 800
New Orleans, LA 70002

or

Faxed to: 504-434-4708

Emailed to: AgencyAppt@myLAHC.org

For LAHC Use Only

Letter sent to current Producer ☐ Yes ☐ No Date Sent: _____ By: _____

**The Effective Date of Initiation, Change or Termination must be a future date. If no date is provided, the Effective Date of Initiation, Change or Termination will be the first of the month following receipt of the Agent of Record Letter (AOR).*