

**AGENT/BROKER OF RECORD CHANGE**

Date of Request: \_\_\_\_\_

Anthem Blue Cross and Blue Shield  
 ATTENTION: VAA101-B000  
 PO Box 27401  
 Richmond, VA 23279  
 Phone: (804) 354-3983  
 Fax: (866) 701-4991

- Anthem Blue Cross and Blue Shield
- HealthKeepers, Inc.
- Peninsula Health Care, Inc.
- Priority Health Care, Inc.
- Anthem Life
- Anthem Dental
- Personal Health Care (Individual)
- Medicare Supplement

Group #(s): \_\_\_\_\_ Policyholder #: \_\_\_\_\_

Group/Individual Name and Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Grp/Ind Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Email Address: \_\_\_\_\_

Please be advised that we wish to name:

\_\_\_\_\_  
 (Agent Name, Anthem Agent ID#, Agency Name)

as our agent representative effective \_\_\_\_\_ for the lines of business shown above  
 (Date)\*

and currently in force. This form replaces any other authorization that may have been

previously completed on an insurance representative for the stated lines of business.

\_\_\_\_\_  
 (Group Decision Maker's or Member's Signature)

\_\_\_\_\_  
 (Date)

\_\_\_\_\_  
 (Print Name and Title of Group Decision Maker)

\_\_\_\_\_  
 (Company Name if applicable)

**To be completed by new Agent:**

As the new agent, I accept the assignment of the above named group/individual as their Agent of Record. I further certify that all the information shown above is correct and complete to the best of my knowledge.

\_\_\_\_\_  
 (Agent's Signature)

\_\_\_\_\_  
 (Agent's Anthem ID #)

\_\_\_\_\_  
 (Date)

\*I also understand that commissions will not be payable until next first of the second month following receipt of the AOR form. It is also understood that this will be included in my book of business based on date of receipt. Individual business change is effective first of month following receipt of request.