Blue Cross
Blue Shield
Blue Care Network
of Michigan

Commission Payment Designation

Agent Name _____
(Please Print)

Home Address _____

_____

_____

Telephone Number:

Business ( ) _____ Home ( ) _____

Fax Number ( ) _____ E-mail Address _____

Commissions should be paid to:

Full Legal Name _____

Address _____

_____

_____

Social Security No. _____
(if individual)

A & H License Number _____
(if individual)

Federal Tax ID No. _____
(If Agency)
(If you want your commission paid to you or you are not incorporated, please use your Social Security Number)

Signature _____ Date _____