Health Alliance Plan Agent of Record Request Form

This form is to be used when a current HAP member wants to make an agent change.

- Member must remain with their current agent for least 1 year, unless no agent currently attached.
- **Form must be signed and dated by member.**
- AOR takes place month following receipt of form
- For Medicare Advantage, you must be certified with HAP to become servicing agent and must continue to be certified each year to maintain renewals.

Please select product: Medicare Advantage Medicare Supplement Individual

Member Name_____ DOB _____

Member MBI_____

Member Subscriber ID_____

As a member of HAP, by signing this form, you are giving permission to:_____ to have access to your HAP plan information.

This includes plan information and premium information and any other general information included on the original application. This does not include any information related to your health and previous medical claims.

Member Signature_____ Date_____

Agent Name_____ Agent NPN_____

Agent Signature_____ Date_____

Medicare Advantage & Medicare Supplement: Form can be emailed to hapmedicareagent@hap.org

Individual: Form can be emailed to: 1HapIndividualSales@hap.org