



**Employer Designation and Agent of Record (AOR)
Form For Kaiser Permanente**

Date:

To: Kaiser Foundation Health Plan, Inc.

Please recognize _____ as our designated insurance consultant for Kaiser Foundation Health Plans. This also confirms that commissions are not allowable.

This letter also constitutes your authority to furnish our designated consultant with all the information that they may request as it pertains to our agreement, rates, benefits, and other data that they may wish to obtain.

We understand that our designated consultant has no responsibility for any deficiencies in the insurance program to which this letter applies until they have had reasonable opportunity to review our policy.

This letter supersedes any agreements previously issued by our company to Kaiser Foundation Health Plan, Inc. This authorization shall remain in effect until such time as it is rescinded in writing.

Sincerely,

Signature of Decision Maker

Date

Print or Type Name of Decision Maker

Name of Company

Kaiser Foundation Health Plan Group #
Renewal Month

KAISER PERMANENTE HAWAII REGION (KPHI)