AGENT OF RECORD
AUTHORIZATION FORM

KAISER PERMANENTE®

SUBSCRIBER INFORMATION

I (the subscriber) authorize the insurance agent/producer listed below to share enrollment, disenrollment, and summary plan information specific to the applicant with the insurance carrier.

I understand that the insurance agent/producer of record may receive monetary and/or nonmonetary payments from Kaiser Foundation Health Plan of the Northwest (KFHPNW) in connection with the purchase of the health plan coverage.

Date

Health record number

Date of birth

Subscriber name

Subscriber signature

AGENT/PRODUCER INFORMATION

I (the agent/producer) have not made any representations to the applicant about any provisions, benefits, conditions, or limitations of the delivery of the policy except through written materials furnished by Kaiser Permanente. The subscriber has been informed that the effective date of the AOR is assigned by Kaiser Permanente. I certify that the information supplied to me by the applicant has been truly and accurately recorded.

Agent number

Agency number

Agent name

Agent signature