

AGENT OF RECORD AUTHORIZATION FORM



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.

Date

Health Record Number

Subscriber Name

Subscriber Signature

Please list all dependents enrolled under the subscriber above:

AGENT/PRODUCER INFORMATION

KP Agency Number (Vendor #)

Agency Name

Agent Name

Agent Signature

Please submit this completed form to
Kaiser Permanente Broker Shared Services Center

Email: CO-BrokerComp@kp.org

Fax: 818.557.3983