THE ICHRA SHOP INSURANCE AGENCY

Janet@ichra.shop | (303) 903-2054

Agency NPN 19498452 | Producer NPN 6650230

I WANT ICHRA SHOP TO BE MY BROKER

GROUP BROKER OF RECORD APPOINTMENT

EMPLOYER / LEGAL GROUP NAME	**CARRIER / ADMINISTRATOR / GENERAL AGENT**
_____	_____
GROUP NUMBER (IF ASSIGNED)	**POLICY / CONTRACT NUMBER (IF ASSIGNED)**
_____	_____
EMPLOYER ADDRESS	**REQUESTED EFFECTIVE DATE**
_____	_____
AUTHORIZED CONTACT NAME	**AUTHORIZED CONTACT EMAIL / PHONE**
_____	_____

To Whom It May Concern:

The employer identified above appoints **The ICHRA Shop Insurance Agency**, including its properly licensed producers, as broker of record for the group benefits identified above. This appointment is intended to replace any prior broker-of-record appointment for the same products, subject to the carrier's or administrator's rules and any applicable rescission period.

This appointment authorizes The ICHRA Shop Insurance Agency to communicate with the carrier, administrator and authorized service partners; obtain quotes, renewals, plan documents, rates, eligibility and account information; assist with plan administration and enrollment; and receive compensation customarily payable to the broker of record, where permitted and disclosed.

The employer understands that carrier-specific forms, waiting periods or additional signatures may be required. This letter does not itself amend coverage, change plan elections, bind insurance, or authorize disclosure of protected health information beyond what applicable law permits. A separate authorization will be completed when required.

APPOINTMENT SCOPE

[ ] Medical / ICHRA or CHOICE Arrangement [ ] Dental [ ] Vision [ ] Life / Disability [ ] Other: _____

EFFECTIVE DATE

[ ] Effective immediately [ ] Effective on: _____

_____	_____
Authorized Employer Signature	**Printed Name and Title**
_____	_____
Date	**Employer Tax ID (last four digits only, if required)**

AGENCY ACKNOWLEDGMENT

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