Broker of Record Transfer Form

GUIDELINES:

1. All fields are required. Incomplete forms will be returned.
2. The Policyholder's "wet" signature is required.
3. All signatures and signature dates must be signed within 30 calendar days of receipt of the form.
4. The transfer effective date will be the first day of the month following receipt of this form. Retroactive transfer dates will not be accepted.
5. Wellcare reserves the right to limit transfers, to deny any request, and to verify the information provided.

SECTION A – Policyholder Appointment Approval:
To only be completed by Policyholder or Parent/Legal Guardian

I appoint _____as my Broker of record. As my Broker of record and as a business associate of Wellcare, my Broker of record will have access to my Protected Health Information (PHI) related to insurance support functions, such as membership maintenance information, plan benefit information and transactions, new product information, and enrollment and disenrollment information. By signing this form, I confirm the Broker listed above significantly assisted me with my enrollment/membership with Wellcare. ***Additionally, by signing this form, I understand any Broker currently designated on this policy will be removed and the new Broker being added will remain in effect until revoked or replaced in writing.***

Policyholder Signature:	**Signature Date:**
Policyholder Printed Name:	**Policyholder Phone Number:**
Policyholder Date of Birth:	**Policy ID Number:**
Broker Printed Name:	**Broker NPN:**

The form may not be signed by anyone other than the Policyholder

SECTION B – Broker Attestation:
To only be completed by the Broker that assisted the Policyholder

By signing this Broker of Record Transfer form, I attest the following:
As Broker of record, I understand that if fraudulent activity of any kind is suspected by Wellcare, Wellcare may choose to terminate the TPME Medicare Agreement in accordance with section 5-1 (*Terminate without cause)* or section 5-2 (*Terminate with cause)* of the TPME Medicare Agreement.

- All information contained on this form is true and accurate
- This form was obtained ensuring all terms and conditions of the TPME Medicare Agreement were followed and met. Failure to meet these terms and conditions can result in termination of the Agreement(s).
- I significantly assisted the Policyholder listed on this form with Wellcare coverage.
- I am properly licensed, contracted, and appointed at the time of this request.

Broker Signature:	**Signature Date:**
Broker Printed Name and Phone Number:	**Broker NPN:**

PLEASE SUBMIT THE FORM IN THE CENTENE WORKBENCH BROKER PORTAL
TICKET TYPE: COMMISSIONS
TICKET SUBTYPE: BROKER OF RECORD CHANGE