

Broker Authorization Letter

Effective Date:

Authorization Expiration:

Blue Cross and Blue Shield of Rhode Island
Attn: Broker Relations
444 Westminster Street
Providence, RI 02903

BCBSRI Group Health
BCBSRI Group Dental
BCBSRI Group Stop Loss

Group Number(s): _____

Group Name: _____

To be completed by Broker:

BCBSRI Broker ID Number:

Broker Name:

Agency Name:

Broker Signature:

Date:

To be completed by General Agent (If Applicable):

BCBSRI General Agent Number:

General Agent Name:

General Agent Signature:

This temporary authorization will allow BCBSRI to release information to the named broker regarding my account, including rates, enrollment and plan information. I understand that while this authority is in force, my existing Broker of Record (if any) will continue to have access to this information from BCBSRI. I also understand that this authorization will not modify any existing broker compensation arrangements (if any).

Company Officer Name:

Title:

Signature:

Date: