McLaren HEALTH PLAN | INDIVIDUAL MEDICAID MEDICARE

Commission Payment Designation

Agent Name: _____

(Print)

Home Address: _____

_____

Social Security No. _____

Telephone Numbers: Business: _____ Cell: _____

E-Mail: _____

Commissions should be paid to:

Important - This information must match the W9.

Full Legal Name: _____

Address: _____

Federal I.D. No.: _____

(**Note: If you want your commission paid to you, or you are not incorporated, please use your SS Number.)**

Agent's Signature: _____

Agent's National Producer No. (NPN): _____ Date: _____