



### Agent of Record Change Request

This form allows my new insurance agent to get information about my Medicare Advantage plan from PacificSource Medicare. I know the agent's commission will be paid out of my monthly premium payments.

Member Information		
Member Name: (First, M.I., Last)		Date of Birth:
Member ID:	Plan Effective Date:	Phone:
Authorization of Agent of Record Change		
I choose this new agent to help me with my PacificSource Medicare Advantage plan. I am aware the new agent is not employed by Pacific Source Medicare. I know this new agent will replace my prior agent. This change will remain until I let the plan know of a new change in writing.		
Signature		
Member Signature:		Date:
Agent Information		
Former Agent Name: (First, Last)		
New Agent Name: (First, Last)		Agent PM#
Company Name:		Phone:

Please complete and sign this form, and return to PacificSource Medicare by:

- Email: [medicareagentcoordinator@pacificsource.com](mailto:medicareagentcoordinator@pacificsource.com)
- Fax: (541) 382-3407 or (208) 395-2682
- Mail: PacificSource Medicare, 2965 NE Conners Ave, Bend, OR 97701

Internal Use Only			
Policy Effective Date:		Policy Type:	
Prior Agent Name & PM#:		Prior Commission:	
AOR Receipt Date:		New Agent Effective Date:	
Updates/Notes Made in Facets _____ OnBase _____		New Agent Commission:	
NOTES:			

PacificSource Community Health Plans is an HMO/PPO plan with a Medicare contract. Enrollment in PacificSource Medicare depends on contract renewal.