

Agent Appointment Form

Please save to your computer, complete and send appointment form by:

Email: CCHP-BrokerSupport@chw.org

Fax: 1-414-266-1611

Mail: Together with CCHP

P.O. Box 1997 – MS6280 • Milwaukee, WI 53201-1997

Agency / Sole Proprietor Information

Commissions are paid to General Agent

Name (first, middle, last)

SSN (Required)

Work Address

Apt. / Suite

City

State

Zip

Agency Name
(Required)

Preferred Number
(Required)

Fax Number

Other Phone

Email Address (REQUIRED) (By giving your email address, you agree to get your contract and other correspondence electronically)

Health License Information

Please attach a copy.

License Type

License Number

NPN

State of Issue

Issue Date

Expiration Date

Has your insurance license been suspended or revoked?

Yes No

Have you ever been convicted of a felony?

Yes No

Have you ever been investigated or fined by an Insurance Regulatory Authority?

Yes No

Do you owe any debt/balance to an insurer, general agent, or financial service institution that has remained overdue for more than 60 days

Yes No

Errors and Omissions Insurance

Applicant or Agency must be noted on the certificate.

Name of Carrier
(attach copy of certificate)

Specific and aggregate amounts
(minimum of \$1 million each)

Exp. Date

Issue Date

Attestation

The application information contained herein is true to the best of my knowledge.

Signature

Date