BROKER OF RECORD CHANGE FORM:
INDIVIDUAL/GROUP ENROLLMENTS [ON & OFF MARKETPLACE]

Complete this form to ensure the correct broker is reflected as the Broker of Record (BOR) on new business enrollments ON and OFF the Health Insurance Marketplace. This form must be signed by both the broker and the primary subscriber or group representative.

A. TYPE OF ENROLLMENT

1) Check one: ☐INDIVIDUAL ☐GROUP

2) Check one: ☐ON MARKETPLACE ☐OFF MARKETPLACE

BOR requests become effective in Alliant's system the month following receipt of this form. (Example: If you submit this form on February 5th, your request will become effective March 1st.)

Note: For ON Market business, you must also contact the Marketplace to make this change. Otherwise, your change will be overwritten in our system when we receive a new file from HealthCare.gov.

B. INDIVIDUAL INFORMATION *(For Individual/Family Plans Only)*

Individual (Primary Subscriber) First and Last Name		Subscriber ID Number	
Mailing Street Address	City	State	Zip Code
Phone Number	Email Address		

C. GROUP INFORMATION *(For Group Plans Only)*

Group (Company) Name	Group ID Number	Phone Number	
Mailing Street Address	City	State	Zip Code
Group Contact First and Last Name	Email Address		

D. SIGNATURE

By signing and completing this document, I instruct Alliant Health Plans to change the Broker of Record associated with my policy to the broker listed below. *This designation shall remain in effect until expressly terminated by the primary subscriber or group in writing.*

Primary Subscriber or Group Signature **X**	Date MM/DD/YYYY

E. Broker OF RECORD INFORMATION

Broker First and Last Name *(as it appears on HealthCare.gov)*	Phone Number
State License Number	National Producer Number (NPN) *(ON Marketplace Only)*
Broker Social Security Number (SSN) or Parent Tax ID Number (TIN)	Marketplace Confirmation Number *(ON Marketplace Only)*
Email Address	

I hereby confirm I helped the above named applicant with quoting, enrollment and/or servicing a health plan. Where required by my agreement with Alliant Health Plans, I also acknowledge I have a copy of the applicant's request that I be assigned as the Broker of Record. I understand if another broker is assigned to the same plan option with a later effective date, Alliant Health Plans cannot assure that I will be the Broker of Record.

For ON Marketplace business, I acknowledge it is my responsibility to contact the Marketplace to ensure I am assigned as the Broker of Record in the Marketplace's system. I also acknowledge I will receive commission for premiums paid only if I have an active CMS certification in the applicable state.

Broker Signature **X**	Date MM/DD/YYYY

Please send this completed form to: Email: BOR@AlliantPlans.com or Fax: (866) 634-8917

Notice of Non-Discrimination

Alliant Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Alliant Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Alliant Health Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact **Customer Service at (866) 403-2785**.

If you believe that Alliant Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Sabrina LeBeau, Compliance Officer, PO Box 1128, Dalton GA 30722, Ph: (706) 237-8802 or (888) 533-6507 ext 125, Fax: (706) 229-6289, Email: Compliance@AlliantPlans.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Sabrina LeBeau is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance

English
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-866-403-2785 (TTY: 711).

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-403-2785 (TTY: 711).

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-403-2785 (TTY: 711)

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-403-2785 (TTY: 711)번으로 전화해 주십시 h 오.

繁體中文 (Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-403-2785（TTY：711）。

ગુજરાતી (Gujarati)
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-866-403-2785 (TTY: 711).

Français (French)
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-403-2785 (ATS : 711).

አማርኛ (Amharic)
ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-866-403-2785 (መስማት ለተሳናቸው: 711).

हिंदी (Hindi)
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-866-403-2785 (TTY: 711) पर कॉल करें।

Kreyòl Ayisyen (French Creole)
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-403-2785 (TTY: 711).

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-403-2785 (телетайп: 711).

العربية (Arabic)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-403-2785 (رقم هاتف الصم والبكم: (711 TTY).

Português (Portuguese)
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-866-403-2785 (TTY: 711).

فارسی (Farsi)
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-866-403-2785 (TTY: 711) تماس بگیرید.

Deutsch (German)
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-403-2785 (TTY: 711).

日本語 (Japanese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-866-403-2785（TTY:711）まで、お電話にてご連絡ください。