



Agent Change Request Form

Member Name _____
(First) (Middle) (Last)

Member ID _____ (9-digit number on your member card)

Please change the agent representing my Asuris Northwest Health health coverage plan from*:

Current Agent Name _____
(please indicate "unknown" if applicable)

To

New Agent Name/Number _____
(agent name) (agent number)

Reason /Comments:

Member Signature _____
(required)

Member Name _____
(please print)

Date _____

Agent of Record Change Requests for **Individual** or **Medicare Supplement**:

ATTN: AOR Changes
Asuris Northwest Health
PO Box 21267 m/s S313
Seattle, WA 98111-3267

Or FAX to (206) 332-6747

Agent of Record Change Requests for **TruAdvantage** or **Part D**:

Consumer Sales
Asuris Northwest Health
PO Box 21267 m/s S304
Seattle, WA 98111-3267

Or FAX to (206) 332-6600

*Note:

1. All requests for changes to the agent of record must come from the health coverage contract holder.
2. The new agent must be appointed with Asuris and authorized to represent the health coverage product you are on.