McLaren Health Plan, McLaren Health Plan Community
and/or
McLaren Health Advantage
Commission Payment Designation

Agent Name: _____
(Print)

Home Address: _____

_____

Social Security No. _____

Telephone Numbers: Business: _____ Cell: _____

Home: _____ Fax No.: _____

E-Mail: _____

Commissions should be paid to:

Full Legal Name: _____

Address: _____

A & H License No. (if individual): _____

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: _____

National Producer No. (NPN): _____ Date: _____

MHP42721082