Agent of Record Form
For individual and family plan use only.

Enrollee Information

Member Number (if available): _____

Name: _____

Mailing Address: _____

Phone #: _____ Email Address: _____

Please appoint _____as my agent of record effective _____ (date) I understand that the named agent will represent my coverage through Mountain Health CO-OP, and that this agent will receive commissions on my coverage. If I have a current agent of record, I wish this agent to be appointed as a replacement.

Member Signature:_____ Date: _____

Agent Information

I accept the assignment of the above named person as his or her agent of record. By signing below I agree that the information on this form is complete and accurate.

Name: _____ ID License #: _____ NPN#: _____

Agency name: _____ Email address: _____

Mailing address: _____

Signature: _____ Date: _____

Send to:
Pedro Rojas
1545 E Iron Eagle Dr
Suite 101
Eagle, Id 83616

Or scan and send by email to:
projas@mhc.coop