BlueCross BlueShield Nebraska

Medicare Supplement Agent of Record Change Request Form

Please complete and sign the following to ensure accurate processing of applicant enrollment and the payment of any subsequent producer commissions, if applicable. The only changes that will be accepted will be from the current plan to a new Medicare Supplement plan.

Please note that ALL requests will be subject to approval by Blue Cross and Blue Shield of Nebraska (BCBSNE).

1. Applicant Information:

Applicant Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

BCBSNE Member ID Number: _____

2. Change Request: Please be advised that we wish to appoint the agent below as the agent of record for our policy.

Agent Name: _____

Agency Name: _____

Agent Number: _____

Application Submitted Date: _____ Requested Effective Date: _____

3. Signatures:

_____ _____

Applicant Signature: Date:

_____ _____

New Agent Signature: Date:

Note: This form must be fully completed and received by Blue Cross and Blue Shield of Nebraska prior to the plan change effective date.

Please return your completed form to the following address:

Blue Cross and Blue Shield of Nebraska
ATTN: Individual Contract Installation
PO Box 3248
Omaha, NE 68180-0001

Fax: 402.548.4685
Email: IndContractInstallation@nebraskablue.com