



FOR **SMALL
BUSINESS**

Date of Request: _____

**Agent of Record Transmittal Form
Covered California for Small Business**

Please complete the information below and send this form to _____
[Insert Contact Entity]

via **email** at _____ or **Mail to:** Covered California for Small Business
[Insert Email Address] P.O. Box 7010
Newport Beach, CA 92658

Consumer Information:

Consumer Name: _____

Covered California System Case No.: _____

Former Agent Information:

Former Agent Name: _____

Former Agent License No: _____

New Agent Certification:

New Agent Certification: New Agent of Record must attach proof of their certification with the California Health Benefit Exchange.

New Agent Information:

New Agent Name: _____

New Agent License No: _____

New Agent Tax Identification Number: _____

New Agent Phone No.: _____

New Agent E-mail Address: _____

New Agent Address: _____
Street/P.O. Box City State Zip Code

Effective Date of Change: _____