



**AGENT OF RECORD AUDIT REQUEST FORM**

Agent Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone Number(\_\_\_\_) \_\_\_\_\_ Email Address: \_\_\_\_\_

\_\_\_\_\_  
Agent Signature

\_\_\_\_\_  
Agent Writing Code

\_\_\_\_\_  
Date

I was not credited for the following \_\_\_\_ (#) enrollment applications. (Please list applicant enrollment information below.)

	<b>Name of Applicant</b>	<b>Medicare#</b>	<b>Date of Birth</b>	<b>Signature Date</b>	<b>Proposed Effective Date</b>
<b>1</b>					
<b>2</b>					
<b>3</b>					
<b>4</b>					
<b>5</b>					
<b>6</b>					
<b>7</b>					
<b>8</b>					

**Other reason(s) for the audit request:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please submit by email or fax to:**  
  
**broker\_commissions\_inquiry@careimprovementplus.com**  
  
**Fax: 443-524-8715**

**Please maintain a copy of this audit for your records. This form MUST be completed in its entirety. We commit to promptly completing the audit and, whenever possible, inform you of the results within 10 business days from date of receipt.**

**Thank you for your business.**