L.A. Care HEALTH PLAN

Insurance Agent Appointment Form (Broker Use Only)

Member First Name:	MI:	Last Name:	
Street Address:	City:	State:	Zip Code:
Email:	Home Phone #:	Cell Phone #:	
Member ID#:		Date of Birth *(MM/DD/YYYY)*:	

Line of Business: LACC

I am appointing the below named as my:

☑ Insurance Agent of Record ☐ Admin of General Agency of Record

For the Benefit Year/Period: 2023 to _____

Insurance Agent/Agency Information:

APAC SERVICE CENTER AND INSURANCE SERVICE

Agency Name:	Title	License:	
APAC INSURANCE AGENCY		0D06186	
Insurance Agent First Name:	**MI:**	**Insurance Agent Last Name:**	
LORETTA		CHAN	
Office Address:	**City:**	**State:**	**Zip Code:**
9668 VALLEY BLVD #103	ROSEMEAD	CA	91770
Email:	**Office Phone #:**	**Cell Phone #:**	
LORETTA@APACCENTER.COM	626-291-2200		

This appointment is only to allow the Insurance Agent to help me do the following: *(check all that apply)*:

☑ Plan Premium Bill Payments ☑ Primary Care Physician/Medical Group Changes

☑ Member ID Card Requests ☑ Update Contact Information

ML2862 1122

Submit form to: Include copy of members' proof of identification with completed form. Upload via your Agency's Secure File Transfer Portal (SFTP). Please allow 1-Business Day for processing. DO NOT email, fax, or mail completed forms. Please use caution when handling Protected Health Information (PHI).
Agent Support: 855-248-7778

This Appointment Form allows the named Agent to:

- Help you with the actions listed, on your behalf.
- Discuss your information, including protected health information (PHI), and financial information.
- The Agent can take the actions listed without you being present or available.
- This is **not** a legal Authorized Representative Form. If you would like someone to act as your authorized representative, then please fill out the authorized representative form.

Member agrees that He/She/They:

- Have reviewed the form, and provided all information before signing.
- Understand the permissions they are giving.
- Understand that the Agent will have access to, and know, their PHI and financial information.
- Understand that the Agent can only help the member on the selected action(s), on their behalf, and cannot act without their prior approval and consent.
- This authorization is valid only for Agents/Agencies currently contracted and in good standing with L.A. Care, and for the benefit period provided above.
- Any termination of the Agent /Agency's contract or termination of Member's enrollment with L.A. Care will automatically terminate this authorization.

Members have the right to:

- Be part of any verbal conversation between the Agent and L.A. Care involving the actions.
- Update or revoke this authorization at any time with a written request to L.A. Care. If changes need to be made to this form, the member will need to resubmit a new form.
- Request a copy of this form.

I understand that my treatment, payment, enrollment, or eligibility for benefits are not affected by me signing this form.

Today's Date	Member's Printed Name	Member's Signature

Agent Agrees:

- Agent/Agency must be contracted and in good standing with L.A. Care, and be the AOR.
- Agent must comply with all state and federal rules, regulations and guidance related to the use, access, disclosure of member PHI and confidential information.
- Agent will take no other actions besides those authorized above by the member.
- Agent must document all conversations and requests made by the member, and provide them to L.A. Care upon request for audit or investigation purposes.

Today's Date	Agent's Printed Name	Agent's Signature
	LORETTA CHAN	

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