



## Request for Online Access

I authorize the person named below to access to the books of business and other protected information indicated on this document. I understand this person will have access to employer information and HIPAA-protected information. I understand it is my responsibility to notify CBIA if a change or termination of this person's access privileges is necessary.

Name \_\_\_\_\_

Title \_\_\_\_\_

Agency Name \_\_\_\_\_

Company Email \_\_\_\_\_

*(must not be a shared email)*

Phone \_\_\_\_\_

Grant access to:

- ☐ CBIA Agent Updates (email)
- ☐ Choiceware quoting tool. *(Access to Choiceware provides access to the entire agency's book of business.)*
- ☐ Commissions *(This allows the person to view all the agency's commissions if they are paid to the agency and not the writing agent.)*
- ☐ Your agency information if you are a Health Connections participant

Grant access to the following agent(s) books of business. This allows them to view, add, change and terminate employee and dependent information for groups under the agent's name.

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

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

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

Authorized by:

Name \_\_\_\_\_

Title \_\_\_\_\_

Email \_\_\_\_\_

Phone \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

***Fax or email this completed form to your CBIA Insurance Sales Representative.***

For CBIA use

Approved by \_\_\_\_\_ Date \_\_\_\_\_