



Producer Certification

Pay Commissions To: Agent _____ OR Agency _____
(indicate one)

Individual Producer Information

Connecticut Producer License # _____

Full Name: _____ SSN: _____

Street: _____

City: _____ State : _____ Zip: _____

Email: _____

Agency Information

(if not affiliated with an agency, indicate N/A)

CT Producer License #: _____

Agency Name: _____ Tax ID # _____

Street: _____

City: _____ State : _____ Zip: _____

Website: _____

I understand that for commissions to be paid, my affiliated agency and I (if applicable) must maintain a current Connecticut producer insurance license and active appointments with all of CBIA Health Connections partners that I intend to write business with.

Signature: _____ Date: _____

RETURN THIS FORM AND A COMPLETED W9 FOR THE COMMISSIONABLE ENTITY TO:

**CBIA Insurance Sales
350 Church St.
Hartford, CT 06103**