



Harvard Pilgrim Health Care — Broker Application

Please type or print your answers. Use a separate answer sheet if necessary.

A. Background

1. Name of firm: _____

2. Principal Address: _____

3. Mailing Address (if different from above): _____

4. Telephone: _____ Fax: _____

5. Email: _____

6. Type of firm (check one): Corporation Partnership Individual

7. Taxpayer I.D. Number: _____

8. Is the firm currently engaged in, owned or controlled by any other business interest? Yes No

If yes, explain: _____

B. Primary Contacts

Name	Title	Email

- In order to complete your application in full you must submit a copy of broker license and errors and omissions coverage.
- You must also complete Harvard Pilgrim Health Care’s Broker Agreement and Business Associate Agreement contract. Please contact Broker Relations at 1-800-424-7285 for a copy of the contract.

I verify that the information contained herein is true and that I am a licensed health insurance broker in good standing with the regulatory authorities. Please direct any questions to Broker Relations at (800) 424-7285. Mail the completed form to Broker Relations, Harvard Pilgrim Health Care, 93 Worcester Street, Wellesley, Massachusetts 02481 or fax to (617) 509-2515.

Signature: _____ Date: _____