UPMC Health Plan / UPMC Health Network

Broker of Record Authorization

If you wish to recognize a broker to represent your UPMC coverage, please provide the following information:

Broker/Agent Name:	
Agency Firm Name (if applicable):	
Select Contractor Broker #:	
Address:	
Telephone:	
Effective Date:	

Your signature below as the authorized company representative allows the individual listed above to act as an agent of UPMC and to receive compensation in the form of monthly commission payments for his/her services. You further understand and agree that the broker does not have the authority to approve your coverage and/or effective date. The broker of record will remain in force continuously unless UPMC receives formal notification of cancellation in writing from your company.

Company:	
Address:	
Authorized Company Representative	
Name(please print):	
Signature:	
Title:	
Date:	