



COMMISSION ASSIGNMENT FORM

1. Assignor Information

Assignor: _____

SSN: _____ - _____ - _____ or TIN: _____

Individual or Entity Type: Individual Corp. Sole Prop. LLC LLP Other _____

Mailing Address: _____

Physical Address: _____

Phone Number: (____) ____ - _____ Ext.: _____ Fax Number: (____) ____ - _____

E-Mail Address: _____

Ins. License No.: _____ Eff. Date: ____/____/____ Exp. Date: ____/____/____

2. Assignee Information

Assignee: _____

SSN: _____ - _____ - _____ or TIN: _____

Individual or Entity Type: Individual Corp. Sole Prop. LLC LLP Other _____

Mailing Address: _____

Physical Address: _____

Phone Number: (____) ____ - _____ Ext.: _____ Fax Number: (____) ____ - _____

E-Mail Address: _____

Ins. License No.: _____ Eff. Date: ____/____/____ Exp. Date: ____/____/____

3. Commission Information

I hereby authorize ODS Health Plan, Inc. to pay the following commissions earned by me under the terms of my Producer Agreement to Assignee (check one):

- All commissions
- Other (please describe) _____

READ CAREFULLY

I understand that this Assignment is subject to the terms and conditions of my Producer Agreement, and that I will remain solely responsible for complying with the terms and conditions of my Producer Agreement. This commission assignment shall commence on the date this form is signed by an authorized representative of ODS Health Plan, Inc.

Assignor	Title (if signing on agency's behalf)	____/____/____ Date
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(continued on back)

Assignment will not be valid unless approved by an authorized representative of ODS Health Plan, Inc.

ODS Authorized Representative

Title

____/____/____
Date