Broker of Record Change Form

Attention: Chorus Community Health Plans

Re: Member ID #(s):

Dear Chorus Community Health Plans,

Please appoint as our exclusive broker.

This letter will rescind all previous broker appointments. I acknowledge that Chorus Community Health Plans will appoint the aforementioned broker on the first of the month following the date of this letter.

All future payable commission will henceforth be made payable to the broker appointed on this letter, until Chorus Community Health Plans receives written confirmation of cancellation.

Thank you,

Signature Date

Please return this form by one of these ways:

- Mail: Chorus Community Health Plans
  Attn: Broker Support Team
  P.O. Box 1997 – MS 6280
  Milwaukee, WI 53201-1997
- Fax: 414-266-1611
- Email: CCHP-BrokerSupport@chorushealthplans.org

Internal Reference:
COR Broker Form– Broker of Record Change Form (Rev 2022.1012)