

Broker Registration Form

Thank you for your effort in enrolling this Employer Member Group in the LIA Health Alliance. Completion of this form establishes a business relationship with the LIA Health Alliance and provides the necessary information to process your commissions quickly. **This form must be submitted with each group enrollment.**

If you choose to have your commissions electronically transferred, please check yes ___ or no ___. If yes, please submit a voided check to identify the bank and account number that is to receive the transfer (payment). This technology expedites the payment process, reduces your administrative efforts and allows you to use bank statements to simplify your record keeping.

If you have any questions, please call the LIA Health Alliance Enrollment Line at **1-800-LIA-5513.**

Section A		
Employer Group Being Enrolled: _____		
Employer Address: _____		
Broker Name/Title: _____		
General	Agent	Affiliation:

Section B	
Broker Name: _____	
Address: _____	
City, State, ZIP Code: _____	
Phone Number: _____	Fax Number: _____
Broker License Number: _____	Tax ID Number: _____
(Please attach copy of Broker license if not GA affiliated)	

Remember, if you are choosing electronic funds transfer, you must include a copy of a voided check in addition to your broker license.

Selling Broker Signature: _____ **Date:** _____

General Agent Signature: _____ **Date:** _____