



# PRODUCER OF RECORD TRANSFER REQUEST - INDIVIDUAL POLICY

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Complete, Sign and Submit this Form To:**

Channel Management  
Wellmark Administrators, Inc.  
PO Box 9232 Station 3W491  
Des Moines, IA 50306-9232  
Fax: (515) 376-9086

**Or Email to:**

[ChannelManagement@wellmark.com](mailto:ChannelManagement@wellmark.com)

**From Our Current Producer:**

Writing Agent Name: \_\_\_\_\_  
Agency Name: \_\_\_\_\_  
Agency Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**To Our Desired New Producer:**

Writing Agent Name: \_\_\_\_\_  
Agency Name: \_\_\_\_\_  
Agency Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you accept my request, I understand that all future inquiries concerning my Farm Bureau Health Plan coverage will be directed to the "New Producer" set forth above. I also understand that Wellmark may contact me and others by phone, email or other means to verify this Producer of Record Transfer Request and to perform other due diligence with respect to this request. This request will remain in effect unless, and until, I rescind it in writing.

I understand that the individual producer or agent identified above is not an agent of Wellmark, and is an independent producer chosen by me to assist in my enrollment into the Farm Bureau Health Plan, and with questions I may have about this product.

I understand that if this request is to change from a Farm Bureau producer to a non-Farm Bureau producer, my monthly payment amount may change.

Dated as of: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Farm Bureau Health Plan ID Number: \_\_\_\_\_  
Signature: \_\_\_\_\_  
Print Name: \_\_\_\_\_  
Phone Number: (\_\_\_\_) \_\_\_\_\_