Dear Agent/ Broker:

This agent of Record (AOR) form gives Molina Healthcare permission to change AOR for your client. (Please do not confuse this with our AOR spreadsheet which allows you to be added if you have not been attributed to your client in our system).

The Molina Marketplace Agent of Record (AOR) form **MUST** be signed by the Subscriber and you the agent. You must have substantially assisted the member with the Molina Marketplace coverage. All AOR forms received will be followed up with a phone call to the member so if possible please provide us with any contact information if available.

All verified AOR forms received before the 15th of the month will not take effect until the following month. All AOR forms received on or after the 15th will take effect the next month (Two Months). We do not back date the change of AOR ever.

Please send all forms back to mpAORrequest@molinahealthcare.com . If you have any further questions please let us know. Our number is 855-885-3179 Option 2.

Thank you,

Molina Marketplace Broker Support Team

Molina Marketplace Agent of Record Form

This Molina Marketplace Agent of Record Form ("AOR Form") shall be completed by a Molina Marketplace member or subscriber ("You" or "Your") to designate an agent as the agent of record ("AOR") associated with Your Molina Marketplace membership. An agent should only be designated as Your AOR if the agent substantially assisted You with Your Molina Marketplace coverage.

All verified AOR Forms received prior to the 15th of each month will be in effect the first day of the following month. Verified AOR Forms received on or after the 15th of the month will be effective the first day of the second following month.

Subscriber (Primary Applicant) Name.....
Subscriber ID, Exchange ID or Member ID..... Subscriber State.....

New Agent of Record Information

Please provide the following information for the agent that You wish to designate as Your AOR:
Agent Name.....
Agent Phone Number.....
Agent E-mail Address.....
National Producer Number *(not applicable to California and Washington)*:.....
Agent Tax ID Number and/or License Number *(California and Washington only)*:.....

Member Attestation

I attest that the above-named agent provided substantial assistance with my enrollment or membership in Molina Marketplace. I understand that by submitting this AOR Form that any prior AOR designation with respect to my coverage will be rescinded, and that the designation of the above-named agent as my AOR will remain in effect until revoked or replaced in writing.

Subscriber (Primary Applicant) Name (Print):.....
Signature:.....
Date:.....

Agent Attestation *(To Be Completed By Agent)*

By signing this AOR Form, I attest to the following:

- I am in compliance with all state and federal licensing, training, registration and contractual requirements that are applicable to Marketplace agents in the subscriber's state.
- I am contracted or affiliated with Molina Healthcare, Inc., and I am appointed to sell the Molina Marketplace product in the subscriber's state.
- If the subscriber's state is a Federally-facilitated Marketplace ("FFM") or State-partnership Marketplace, that I met all FFM registration and licensing requirements *prior to* assisting the above-referenced subscriber with his or her membership or enrollment in Molina Marketplace.

Agent Name (Print):.....
Agent Signature:..... Date:.....

This form should be submitted by Your AOR to mobrokersupport@molinahealthcare.com

MOLINA HEALTHCARE