CareValue

AHIP Promotion Verification Form

Please complete, sign and submit this form to qualify for full payment of your 201 AHIP fee by Care Value, Inc. You must complete the member information for the five members you enrolled during AEP (October 15th December 7th, 201 to qualify.*

Agent Personal Information

Agent Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ E-mail Address: _____

Members Enrolled/Issued During AEP (October 15th December 7th, 201 for 1/1/1 effective date.

Member Name	Date Enrolled	Carrier
1.		
2.		
3.		
4.		
5.		

*Agent must new to Care Value, Inc. (CVI) within the qualifying year. Enrollments for this promotion for AHIP must be with carriers the agent is appointed with through CVI, with eligibility for this program being determined by CVI. Agent must abide by CVI's compliance program described to participate in the promotion. Not affiliated with or endorsed by the Federal Government or Social Security Administration.