BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

Mail to:
Blue Cross and Blue Shield of Florida
Attention: CPIM Delegate Administrator
8928 Freedom Commerce Parkway, FCC1-1
Jacksonville, Florida 32256

Channel Partner Office Administrator Request

This form must be completed for each individual being granted permissions for the agency named below. If more than one person should be granted permissions, please make a copy for those person(s). Due to the confidentiality of the information being viewed, BCBSF cannot accept a scanned or faxed copy of this form. We must receive either an original copy with a wet signature via US Mail or a completed form submitted via the BCBSF AcessBlue website. If you have questions regarding this form, you may contact the Agent Service Center at (800) 267-3156.

Agency Information

Agency Name	Tax Identification Number		Agency Code
Street Address			Telephone Number ( )
City	State	Zip	Fax Number ( )

Office Administrator Information

Office Email Address			
Last Name	First Name	Middle Initial	Suffix (Jr., Sr.)
Date of Birth (mm/dd/yyyy)		SSN	Gender ☐ M ☐ F
Home Address (if different from above)		Telephone Number ( )	
City		State	Zip

Is the Office Administrator also an appointed Agent with BCBSF?

☐ No ☐ Yes, License #_____

Action

☐ Add ☐ Remove ☐ Update Only ☐ Transfer Office

(If the above individual represents multiple satellite offices, please complete page 3)

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Tier ☐ I ☐ II ☐ III

(See below for a list of capabilities available with each tier assignment. Note: For each associated Agency Satellite office, an individual can only be associated with one tier.)

I,_____, on behalf of_____ (Agency Code:_____),
(Agency Owner) (Agency Name)
hereby authorize the above individual access to Agency level permissions.

I acknowledge that if I have selected the Tier III option, which includes the Commission and Compensation module, I am designating the above named individual access to this module, which will include full viewing and downloading capabilities of all the commission statements for Group Health and Ancillary products as indicated for my agency and any satellite offices.

I further understand that by releasing my private User ID and PIN to this individual or to other individuals not included in this authorization will allow them access to this module. In the event the security is violated it is my responsibility to notify BCBSF to re-set all authorizations.

I also understand Blue Cross and Blue Shield of Florida (BCBSF) is not liable for the security of this information in the event I fail to notify BCBSF of the termination or change in status of the above named individual.

By signing this form I certify that I have read and understand the above statements, as well as verify that all of my selections are complete and accurate.

Agency Owner Signature_____Date_____

Each individual must be assigned to a single tier. The table below indicates the capabilities available for each of the tiers.

Tier 1	Tier II	Tier III
1. All Rating Tools	1. All Rating Tools	1. All Rating Tools
2. Print Temporary ID Cards for a Group	2. Print Temporary ID Cards for a Group	2. Print Temporary ID Cards for a Group
	3. Ability to View Account Information (Paid-to-Dates, Benefits, Demographics) for all Agency accounts	3. Ability to View Account Information (Paid-to-Dates, Benefits, Demographics) for all Agency accounts
		4. Ability to View and Print Commission Reports

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Channel Partner Office Administrator Agency Location Request

For the office Administrator named on page 1, please list all locations for this agency and select the tier type for each of the locations.

Agency Physical Location	Agency Code	Tier Type (Select one for each location.)
		☐ I ☐ II ☐ III
		☐ I ☐ II ☐ III
		☐ I ☐ II ☐ III
		☐ I ☐ II ☐ III
		☐ I ☐ II ☐ III
		☐ I ☐ II ☐ III
		☐ I ☐ II ☐ III
		☐ I ☐ II ☐ III
		☐ I ☐ II ☐ III

RESET FORM