

Commission Notice

Commissions will be paid according to the terms of the most recent MGA contract or commission schedule on file.

Producer Name (Please print): _____

Social Security Number: _____ - _____ - _____

Complete this section only if commissions are payable to an agency. Commission paid to an agency can only be changed by obtaining a written release from the agency or a broker of record letter from the group.

Agency Name (Please print): _____

Federal Tax ID Number: _____ - _____

Complete this section only if commissions are payable to more than one producer or agency. NOTE: The total percentage of commissions listed below must be 100 percent.

PRODUCER OR AGENCY NAME (Please print.)	
SOCIAL SECURITY OR FEDERAL TAX ID NUMBER	PERCENTAGE OF COMMISSION _____ %
PRODUCER OR AGENCY NAME (Please print.)	
SOCIAL SECURITY OR FEDERAL TAX ID NUMBER	PERCENTAGE OF COMMISSION _____ %
PRODUCER OR AGENCY NAME (Please print.)	
SOCIAL SECURITY OR FEDERAL TAX ID NUMBER	PERCENTAGE OF COMMISSION _____ %

I hereby certify that I, and any other agent or producer who will receive commissions, do hold valid Life, Accident and Health Licenses issued by the state in which this document was executed. I have reviewed all enrollment and application materials and, to the best of my knowledge, all of the information is correct. I know nothing unfavorable about this employer or individual(s) applying for insurance. Furthermore, I certify that this employer is a bonafide business establishment and that participation and contribution requirements have been met. Eligibility provisions and pre-existing condition limitations have been fully explained to and understood by the employer identified in this document.

I understand that I represent the interest of the applicant for insurance, not Trustmark Life Insurance Company, and have advised my client not to terminate any existing coverage until receiving notice that the coverage being applied for by this application is accepted. I understand that I have no right to bind this coverage, to alter terms of the insurance contract or application in any manner or to adjust any claim for benefits under the insurance contract.

Name of employer applying for insurance (please print): _____

Producer signature: _____ Date signed: _____

Office Use Only

Group No. _____ **State** _____ **Eff Date** _____ **MGA** _____ **No. of Lives** _____