CIGNA

COMPENSATION ACKNOWLEDGMENT FORM (CAF-4)

To be completed by:
Field Sales and Producer

Segment: ☐ Small Case ☐ Mid-Market ☐ National

Contract/Situs State ______________

Account Name	Account Group Number	HMO Site	Coverage Name	Comp. Eff. Date	Estimated Annual Premium	Total Account Flat %	Producer Share %	$ Flat Amt (Not for Small Cases and CDH)

ALL COMMISSION LEVELS ARE SUBJECT TO UNDERWRITING APPROVAL. ANY COMMISSION LEVELS THAT EXCEED LEGAL LIMITS WILL BE REDUCED. FLAT PERCENTAGES OR DOLLAR AMOUNTS MAY BE ADJUSTED DURING THE POLICY YEAR IN RESPONSE TO FLUCTUATIONS IN PREMIUM.

Producer Name (Signature) ______ Date ______

Producer Name (Print) ______ SSNO ______ Birth Date ______

Firm Name ______

Street Address, P.O. Box # ______

City ______ State ______ ZIP ______

Phone Number ______ FAX Number ______

E-Mail Address ______

****CHECKS ARE TO BE MADE PAYABLE TO****

Producer or Firm Name (Print) ______ SSN/TAX ID ______

****GENERAL AGENCY (NY, NJ if applicable)

BENEFIT SOLUTIONS
6 HIGH POINT DR. 2ND FLOOR
WAYNE NJ 07470
MASTER BROKER #

General Agent Name ______ Tax ID# ______

CIGNA CHC Sales Representative's Signature ______ Date ______

Underwriter's Signature ______ Date ______

CIGNA CHC Sales Representative (Print) ______

Underwriter Name (Print) ______

Sales Office ______ Telephone Number ______

Underwriter Office ______ Telephone Number ______

Connecticut General Life Insurance Company
CIGNA HealthCare, CIGNA Dental Health