

PLEASE FILL IN ALL (★) AREA'S!!



**COMPENSATION ACKNOWLEDGMENT FORM
(CAF-4)**

To be completed by:
Field Sales and Producer

Segment: Small Case
 Mid-Market
 National

Contract/Situat State _____

OneRate/One Bill Customer _____

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	****CHECKS ARE TO BE MADE PAYABLE TO****	
★ Producer Name (Print)	★ SSNO	★ Birth Date	★ Producer or Firm Name (Print)
★ Firm Name			★ SSN/TAX ID
★ Street Address, P.O. Box #			
★ City	★ State	★ ZIP	
★ Phone Number	★ FAX Number		
★ E-Mail Address		****GENERAL AGENCY (NY, NJ if applicable)****	★ Tax ID#
		★ General Agent Name	

_____ 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

▶ ANY MISSING INFORMATION WILL RESULT IN COMMISSIONS BEING HELD!!

▶ PLEASE SEND A COPY OF YOUR INDIVIDUAL LICENSE.