

{EMPLOYER GROUP LETTERHEAD}

{DATE}

**MVP Health Care
Broker Administration
625 State Street
Schenectady, NY 12305**

Group Name _____

Group # _____ - **Medicare Advantage Plan(s)**
(if existing group)

This confirms that as of (**EFFECTIVE DATE**) we have appointed (**NAME OF BROKER**) on behalf of (**BROKER AGENCY**) as our exclusive Insurance Broker with respect to our Medicare Advantage Health Insurance Plan.

Sincerely,

(Signature of Officer of Company)

(Title)