WellCare®

APPLICATION FOR CERTIFICATION TO MARKET WELLCARE PRODUCTS

APPLICANT INFORMATION

PLEASE COMPLETE ALL REQUIRED FIELDS (DENOTES A REQUIRED FIELD)*

*First: Middle Initial: *Last: Suffix (Jr, Sr):

*Email Address:

*Date of Birth: *SSN/FEIN:

*Home Phone: *Work Phone:

*Mobile Phone: Company Phone (If Applicable):

*Home Address: *(NO PO BOX)*
Street
City *State* *Zip Code*

*Business Address *(NO PO BOX):*
Street
City *State* *Zip Code*
☐ Same as Home Address

--NOTE: Payments are mailed to the billing address provided on the Supplier Registration Form--

LICENSE / MARKETING STATE INFORMATION

* In which state do you hold your resident license to sell healthcare? _____

WELLCARE HIERARCHY *(OPTIONAL)*

PLEASE LIST YOUR IMMEDIATE UP-LINE

	NAME	WELLCARE PRODUCER ID
FMO		
SGA	Sala & Associates, LLC	323638
MGA		
GA		

FOR WELLCARE HEALTH PLANS, INC. OFFICE USE ONLY

ASSIGNED MARKET NAME: _____

DISTRICT SALES MANAGER NAME AND PID: _____

REGIONAL BROKER MANAGER NAME AND PID: _____

Agent Signature: _____