First Sierra Marketing Assistance Program

Reimbursement Request Form

AGENT NAME: ____

AGENT PHONE: ____

AGENT EMAIL: ____

AGENT MAILING ADDRESS: ____

____

TOTAL RECEIPTS ATTACHED: ____

REIMBURSMENT REQUESTED: ____

QUARTER QUALIFIED: ____

AGENT SIGNATURE ***DATE***

**By signing, you agree to the terms and conditions of the program and that all marketing must be conducted in compliance with all applicable federal and state laws. Typing your name is equivalent to a handwritten signature. **

Return this request form along with all other required documents by fax (877) 315-3099 or via secure upload at www.myseniorsales.com .

Thank you for placing your Medicare health insurance business with First Sierra.