Revised 11.24.08

APPOINTMENT PAPERWORK – FAX COVERSHEET

Applicant Profile

Full Name: ____
Last *First* *M.I.*

E-mail Address: ____

Hierarchy & Commission Information

Direct Up-line Name/ Manager Name ____

Up-line/Manager e-Agent Center ID:____________________________ Manager's American National ID_____________

Division President Name ____

Applicant Commission Level____ Unsure? Contact your up-line manager

To expedite processing return the following by fax or e-mail to 972.915.3288 or contracting@AHCPsales.com

- ☐ **page 1** **Fax Coversheet**
- ☐ **page 2 - 3** **Agent Agreement**
- ☐ **page 4** **Confidential Questionare**
  NOTE: To avoid delays, you MUST include a detailed explanation for all YES answers to background questions
- ☐ **page 5** **HIPPA Business Associate Agreement**
- ☐ **page 6** **Appointment Fee Acknowledgement -- Copies of Insurance License(s) are required**
- ☐ **page 7** **Direct Deposit Authorization -- Copy of Voided Check Request**
- ☐ **page 8** **W-9**

You will receive e-mail appointment confirmation in approximately 7-10 working days.

AHCP Website: www.AHCPsales.com
Training: http://www.AHCPsales.com/calendar.html
Quoting: http://www.AHCPsales.com/get_quote.html

Questions? Call 877-228-8773 or e-mail us at contracting@ahcp-ausa.com

AHCP
America's Health Care Plan

AGENT AGREEMENT

The AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS (the "Company") is hereby requested to make application to the Department of Insurance of the State of ______________ for the issuance of a health insurance agent's license/appointment authorizing me to solicit applications on behalf of the Company.

I, ______________________________ ,hereby agree that your consent to the issuance of such license/
Printed Name
appointment is subject to, and I hereby agree to be bound by, each and all of the following conditions:

1. That I shall be an agent assigned to the jurisdiction of the ***America's Health Care Plan***.

2. That the Company has no obligation to me for commissions, expense allowances or any form of compensation whatsoever in connection with the services performed and expenses incurred by me in the solicitation of applications for insurance issued by the Company, it being expressly understood that I am under direct contract with the ***America's Health Care Plan*** who has agreed to compensate me for such services;

3. That I shall comply with the rules, regulations and rate books of the Company, the laws of the State of ______________ , and the regulations of the Department of Insurance relating to my activities in the solicitation of insurance;

4. That I shall not alter, modify, waive or change any of the terms, rates or conditions of any advertisements, receipts, policies or contracts of the Company in any respect;

5. That I shall promptly remit tothe ***America's Health Care Plan*** or the Company any and all monies or securities received by me on behalf of the Company as full or partial payment of first year or renewal premiums, or any other item whatsoever;

6. That I shall not obligate the Company nor incur expense in its behalf in any manner whatsoever;

7. That I shall not attempt systematically to rewrite or replace customers of the Company with other carriers. Should I do so, I will forfeit all compensation payable to me as a result of my sales of the Company's insurance products, and my appointment with the Company, if still in effect, shall be revoked immediately; and

8. That the Company may, without liability to me whatsoever, upon request of the ***America's Health Care Plan*** or upon its own initiative, cancel my license/appointment at any time.

A photographic copy of this authorization shall be as valid as the original.

IN WITNESS WHEREOF, I have affixed my signature this_____ day of_____________, 20____ .

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS

Company Name

By: ______________________

Title: ______________________

____

Print Applicant's Name **Applicant's Address** **Applicant's Phone #**

Applicant's Email **Applicant's SS #** **Applicant's DOB**

Signature of Applicant

AUTHORIZATION TO OBTAIN INFORMATION

I hereby authorize any Insurance Company, Agency, or other organization or any individuals to give to American National Life Insurance Company of Texas (herein referred to as the Company) or its designated representative any and all information which they may have about me, whether or not in their records. I release any individual or organization issuing information from all liabilities for any damage whatsoever for giving information.

I understand that the Company may, as part of its normal procedure, request that an investigative consumer report be made whereby information is obtained through third parties such as past business associates, employers, financial sources, and others with whom the applicant may be acquainted and hereby authorize such an investigation be made I also authorize the Company, through designated representatives or any third parties to conduct investigations into my background and to ascertain whether or not have engaged in any past criminal activity.

I have read, on the date shown below, the above statements and understand that in signing this form, I authorize the Company to make or have made any such investigations. I have the right to make a written request to the Company's home office within a reasonable period of time for additional, detailed information concerning the nature and scope of any investigations.

In addition, the undersigned specifically attest that the Social Security Number or Tax Identification Number on the application is the correct number for the entity applying for appointment with the Company.

Signature ______________________ **Date** ______________________

American National Life Insurance Company of Texas

Post Office Box 1996 • Galveston, Texas 77553-1996
HLAC@ANICO.com

CONFIDENTIAL HISTORY QUESTIONNAIRE
PLEASE TYPE OR PRINT

Name ____________________ Social Security No. ____________

Corporate Name ____________________ Corporate IRS No. ____________
(All principals of the corporation must complete a personal history form, if agreement is to be in corporate name)

Mail to: Business ❑ Residence ❑ **Do not abbreviate address**

AC Fax No.

Business address: ____________________
Street or P. O. Box City State Zip AC Phone No.

Residence address: ____________________
Street or P. O. Box City State Zip AC Phone No.

Street address required for supply shipments ____________________
Street City State Zip Email address

LICENSE INFORMATION:
In what States are you currently licensed?

STATE	LIFE	A&H	LICENSE NO.

SEE ATTACHED LICENSES

Do you wish to apply for non-resident appointment?________ If "yes", attach state appointment fee(s) and Non-Resident State License(s). We will contact you further regarding any other required forms.

PERSONAL DATA

Has your license ever been revoked? ________ (If "yes", please give details) ____________

Are you currently representing American National? ________ Have you ever represented American National? ________

If yes, when, what division and in what capacity? ____________

Do you carry E & O Insurance? Yes ❑ No ❑ If yes, give name of Insurer, Policy Number, Effective Date, and Amount.

The Violent Crime and Control Act of 1994 makes it a criminal offense for anyone who has been convicted of any criminal felony involving dishonesty or a breach of trust to willfully engage in the business of insurance. Have you ever been indicted or convicted of any such felony?________ Have you been arrested for any other crime?________ If "Yes," give specifics as to charge, date, jurisdiction and outcome on a separate sheet of paper.

Do you now have or have you ever had any federal, IRS, or state tax liens, or garnishments? Yes ❑ No ❑

Have you ever filed or been declared bankrupt? Yes ❑ No ❑ If "Yes," attach documentation of final disposition.

Have you ever been disciplined by a state insurance department?________ If "Yes," please give specifics.

Are you presently indebted to any insurance company? Yes ❑ No ❑ Amount ____________

What Insurance Carriers are you currently representing? ____________

Type of Contract: ____________

Have you sold insurance under another name within the past five years? Yes ❑ No ❑ Explain:

Date Of Birth: ________ Place Of Birth: ________ Married ❑ Single ❑ Spouse Name: ________

HIPAA BUSINESS ASSOCIATE CONTRACT
WITH
AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS

This Contract is entered into on this ______ day of _______________, 200__, by and between American National Life Insurance Company of Texas (the "Covered Entity") and _________________________________ (the "Business Associate"). This Contract is effective as of the compliance date of the Privacy Rule and Security Rule as defined herein.

WHEREAS Business Associate and Covered Entity have entered into a contract through which Business Associate provides services related to health insurance products issued by or on behalf of the Covered Entity, and

WHEREAS the disclosure of certain individually identifiable health information will be regulated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended from time to time, and the regulations promulgated thereunder, effective in April 2003, and

WHEREAS Covered Entity may from time to time disclose to Business Associate certain individually identifiable protected health information ("PHI") that is subject to protection under HIPAA,

WHEREAS Business Associate and Covered Entity desire that their contract complies with the applicable provisions of HIPAA and the Privacy Rule, including, but not limited to, Title 45, Sections 164.502(e) and 164.504(e) of the Code of Federal Regulations ("CFR").

NOW THEREFORE, for and in good consideration of the premises and other good and valuable consideration, the receipt of which is hereby acknowledged, it is agreed by and between the parties hereto that the terms listed below are made a part of their contract and provide a full statement of their responsibilities.

Definitions

(1) "Individual" shall have the same meaning as the term "individual" in 45 CFR §164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR §164.502(g).

(2) "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164, Subparts A and E. Additionally, any references herein to the Privacy Rule means the section as in effect or as amended, and for which compliance is required.

(3) "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Parts 160 and 164, Subparts A and C.

(4) "Protected Health Information" or "PHI" shall have the same meaning as the term "protected health information" in 45 CFR §164.501, limited to the information received from or created/received by the Business Associate on behalf of the Covered Entity.

(5) "Required by Law" shall have the same meaning as the term "required by law" in 45 CFR §164.501.

(6) "Secretary" shall mean the Secretary of the Department of Health and Human Services ("HHS") and any other officer or employee of HHS to whom the authority involved has been delegated.

General

Business Associate shall take all necessary actions consistent with HIPAA's requirements to safeguard the PHI that Covered Entity discloses to Business Associate in connection with Business Associate's duties under the Contract. Business Associate may not use or further disclose PHI in a manner that would violate HIPAA's requirements if done by the Covered Entity.

Permitted Uses and Disclosures

Business Associate is permitted to use and disclose PHI from the Covered Entity as follows:

Duties of Business Associate

Business Associate shall:

(1) Not use or further disclose the information other than as permitted or required by this contract or as required by law.

(2) Use appropriate safeguards to prevent use or disclosure of PHI disclosed by the Covered Entity or Business Associate other than as provided for by this Contract.

(3) Have appropriate procedures in place for mitigating, to the extent practicable, any deleterious effect from the use or disclosure of PHI in a manner contrary to this Contract or the Privacy Regulations.

(4) As soon as reasonably practical, report to the Covered Entity any use or disclosure of the information not provided for by its contract of which it becomes aware.

(5) Ensure that any agents or subcontractors to whom it provides PHI received from or created/received by the Business Associate on behalf of the Covered Entity agree to the same restrictions and conditions that apply to the Business Associate with respect to such PHI.

(6) Make available PHI in accordance with rules regarding access of individuals to information under HIPAA.

(7) Make available PHI for amendment and incorporate any amendments to PHI in accordance with HIPAA.

(8) Make available the information required to provide an accounting of disclosures in accordance with HIPAA.

(9) Make its internal practices, books and records relating to the use and disclosure of PHI received from, or created/received by Business Associate on behalf of Covered Entity available to the HHS Secretary for the purposes of determining Covered Entity's compliance with HIPAA. Business Associate shall immediately notify Covered Entity upon receipt or notice of any request by the Secretary to conduct an investigation with respect to PHI received from the Covered Entity.

Security of Electronic PHI

If applicable, Business Associate shall take reasonable and necessary measures to comply with the Security Rule as set forth in HIPAA, including but not limited to:

(1) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Covered Entity.

(2) Ensure that any agents or subcontractors who will have access to electronic PHI will also implement reasonable and appropriate safeguards to protect the information.

(3) Report any security incident of which it becomes aware to the Covered Entity including any attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

Uses and Disclosures for the Proper Management or Legal Responsibilities of the Business Associate

Business Associate may, if necessary, use and disclose PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate. However, in order to disclose PHI:

(1) The disclosure must be required by law; or

(2) The Business Associate must obtain reasonable assurances from the person to whom the information is disclosed that it will be held in a strict and confidential manner and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person; and

(3) The person must notify the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

Data Aggregation Services

Business Associate will provide data aggregation services as set forth in 45 CFR §164.501, relating to the health care operations of Covered Entity.

Right to Audit

Covered Entity and its representatives shall be entitled, with ten (10) business days prior written notice to the Business Associate, to audit the Business Associate from time to time to verify Business Associate's compliance with the terms of this Contract. The Covered Entity shall be entitled and enabled to inspect the records and other information relevant to Business Associate's compliance with the terms of this Contract. Covered Entity shall conduct its review during the normal business hours of Business Associate, as the case may be, and to the extent feasible without unreasonably interfering with such entity's normal operations.

Termination

Covered Entity may terminate the Contract without penalty or recourse to Covered Entity if Covered Entity determines that the Business Associate has violated a material term of the contract.

At termination of the Contract, the Business Associate shall return or destroy all PHI received from or created or received by the Business Associate on behalf of the Covered Entity that the Business Associate still maintains in any form and retain no copies of such information. If such return or destruction is not feasible, the Business Associate must continue to protect such PHI in accordance with this Contract and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible. This provision shall apply to PHI that is in the possession of agents or subcontractors of Business Associate.

Further Assurances

In order to ensure that this Contract is consistent with HIPAA, the Business Associate agrees that this Contract may be modified from time to time upon written notice from Covered Entity to Business Associate as to the revisions required, to make this Contract consistent with HIPAA.

Nothing expressed or implied in this Contract is intended to confer, nor shall anything herein confer, upon any person other than the Business Associate and Covered Entity and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

Both Business Associate and Covered Entity agree that the individuals' signatures appearing below have both the legal capacity and authority to enter into a binding contract on behalf of the entities they represent.

IN WITNESS WHEREOF, the parties hereto have caused this Contract to be signed and delivered by their duly authorized representatives, as of the date set forth above.

Agent Signature ____________________ Date ____________

Print Agent Name ____________________

Social Security Number ____________________

American National Life Insurance Company of Texas ____________________ Date ____________

Please make CHECK payable to AHCP.
To expedite process -- Fax or Scan paperwork, then mail your check to: AHCP Contracting Dept. -- ANTEX
4929 W Royal Lane, # 200 Irving, TX 75063

A= Simultaneous submission…Effective date is date agent is contracted with ANICO
AA= Simultaneous submission…State must receive notification of the appointment within 30 days from the date of the application
AAA= Simultaneous submission…ANICO must notify the state of the effective date within 15 days from the date of the application
B= Effective date is the day the appointment form is mailed from ANICO
C= Effective 7 business days after the form is mailed from ANICO
D= Not an immediate state…Effective date is determined by the state

State	Fee Resident	Fee Non-Resident	Appointment Effective Date
AK	No Appointment Fee		AAA
AZ	No State Appointment Required		A
AR	$20.00 Sponsoring Co Pays	$60.00	AAA
CA	$24.00	$24.00	AAA
CO	$ 0	$ 0	A
CT	$20.00	$40.00	AAA
DC	$25.00	$25.00	AA
DE	$25.00	$25.00	AAA
FL	$60.00	$60.00	AA
GA	$10.00	$10.00	A
HI	No Appointment Fee		AAA
ID	No Appointment Fee		AAA
IL	No State Appointment Required		A
IN	No State Appointment Required		A
IA	$10.00	$10.00	AA
KS	$5.00	$5.00	AA
KY	$40.00	$50.00	AAA
LA	$20.00	$20.00	AAA
ME	$30.00	$70.00	AAA
MD	No Appointment Fee		AA
MA	$75.00	$75.00	AAA
MI	$5.00	$5.00	AAA
MN	$10.00	$10.00	AAA
MS	$10.00	$10.00	AAA
MO	No Appointment Fee		AA
MT	No Appointment Fee		AAA
NE	$8.00	$8.00	AAA
NV	$15.00	$15.00	AAA
NH	$50.00	$50.00	AAA
NJ	$25.00	$25.00**Anico only	AAA
NM	$23.00	$23.00	AAA
NC	$20.00	$20.00	AA
ND	$10.00	$10.00	AA
OH	$20.00	$20.00	AA
OK	$40.00	$40.00 No Fee Brokers	AAA
OR	No Appointment Fee		A
PA	$15.00	$15.00	AA
RI	$25.00	$25.00 E & O required	A
SC	$40.00 – Sponsoring Company Pays		AAA
SD	$10.00	$20.00	AAA
TN	$15.00	$15.00	AAA
TX	$10.00	$10.00	AA
UT	No Appointment Fee		AA
VT	$60.00	$60.00**Anico only	AAA
VA	$12.00	$12.00	AA
WA	$20.00	$20.00	AA
WV	$25.00	$25.00	AAA
WI	$7.00	$24.00	AAA
WY	$15.00	$15.00	AAA

I, ________________________ agree to mail a check payable to AHCP in the amount of $_______________ , which totals all fees associated to the states I am currently requesting appointments for with American National.

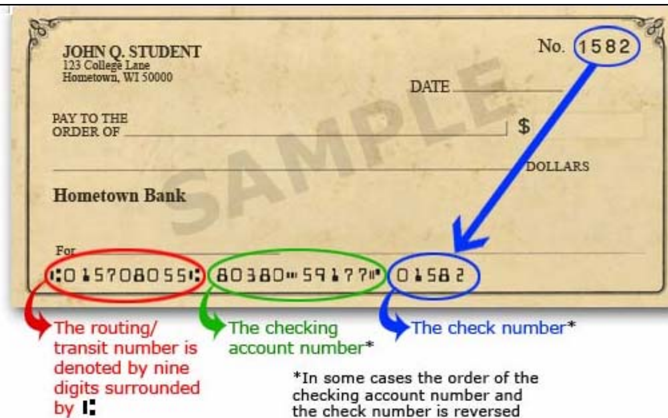
Agent Signature: ____

SIGN HERE

Authorization for Automatic Deposit

I (We) Hereby authorize AHCP to initiate direct deposit of commissions and, if necessary, make corrections for any entries made to my account in error.

Agent or Agency Name	
Social Security Number or Tax ID Number	
Phone Number	Email Address
Please indicate transaction type: [ ] Set-Up [ ] Change [ ] Cancel	
Please indicate type of account: [ ] Checking [ ] Savings	
Name of Financial Institution:	
Bank—City, State, Phone Number:	
Routing Number:	
Account Number:	



If you don't have paper checks, contact your bank to obtain your bank routing number and account number information

SIGN HERE

Agent Signature_________________________________**Date**________________

PLEASE INCLUDE A COPY OF A VOIDED CHECK

Form **W-9**
(Rev. January 2002)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type
See **Specific Instructions** on page 2.

Name

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ▶ ------------------ ☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). **However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 2.** For other entities, it is your employer identification number (EIN). If you do not have a number, see **How to get a TIN** on page 2.

Note: *If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.*

Social security number

or

Employer identification number

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
2. I am not subject to backup withholding because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified me that I am no longer subject to backup withholding, **and**
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item **2** above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item **2** does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 2.)

Sign Here Signature of U.S. person ▶ SIGN HERE **Date** ▶

Purpose of Form

A person who is required to file an information return with the IRS must get your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to give your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee.

If you are a foreign person, use the appropriate Form W-8. See **Pub. 515,** Withholding of Tax on Nonresident Aliens and Foreign Entities.

Note: *If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.*

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 30% of such payments **after** December 31, 2001 (29% **after** December 31, 2003). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will **not** be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester, or

2. You do not certify your TIN when required (see the Part II instructions on page 2 for details), or

3. The IRS tells the requester that you furnished an incorrect TIN, or

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions on page 2 and the separate **Instructions for the Requester of Form W-9.**

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.