

Agent/Producer Information

Full Name: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

_____ *City State ZIP Code*

Home Phone: () _____ Alternate Phone: () _____

E-mail Address: _____

Social Security Number: _____

Tax ID: _____ Date of Birth: _____

Hierarchy & Commission Information

Direct Up-line/Mgr Name : _____ DP _____

Applicant Commission Level: _____ (Unsure? Contact your up-line manager)

Advance Options: 3 month 6 month 9 month Earned *** No interest (Advance options will have a 3% administrative fee)**

RETURN PACKET TO AHCP CONTRACTING DEPARTMENT

You can e-mail completed forms to Contracting@AHCPsales.com or FAX them to (972) 915-3288

- Page 1** AHCP Appointment Coversheet (this page)
- Pages 2-5** Prospective Broker Application
 - Explanation page included
- Page 6** Fair Credit Report Act
- Page 7** Assignment of Commission and Other Compensation
- Page 8** Independent Broker Contract Signature Page
- Page 9** Appointment Fee Credit Card Authorization Form
- Page 10** Direct Deposit Authorization (Commissions paid by AHCP)
- Page 11** W-9
- Pages 12-14** AHCP Producer Agreement

ADDITIONAL REQUIREMENTS

- License copies
- Supporting documentation for any "Yes" answers to background questions

New appointments take approximately 5-7 business days to process. Once your appointment is completed you will receive a welcome email from AHCP contracting.

Be sure to visit our site for On-Demand Product Training www.AHCPsales.com

PROSPECTIVE BROKER APPLICATION

GRIC Manager/Representative **Cheryl Pickett** Email to: kblicensing@goldenrule.com

Independent Broker Financial Services Company Name **F3A02 - AMERICAS HEALTH CARE/RX PLN**

Complete Name _____ I prefer to be called: _____

Name of Agency or Company _____

Business Street Address _____

(Required for Supplies - No PO Box address)

Business Mailing Address _____

City _____ County _____ State _____ ZIP _____

Business Phone (____) _____ Fax (____) _____ E-mail _____

Home Address _____

City _____ County _____ State _____ ZIP _____

Home Phone (____) _____ Birth Date _____ Gender _____

Social Security No. _____ National Producer No. _____

Length of time in present community _____. If less than five years, please provide previous address(es).

Please check the appropriate box.

All commissions are to be paid to me.

All commissions are to be paid to **AMERICAS HEALTH CARE/RX PLN**

000005289

Agency, Company, or Name

Tax ID No.

Please answer all questions. (If YES, include details of who, what, when, and dollar amounts on an additional form.)

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Have you ever had an appointment terminated by any insurance company or financial services institution (for reasons other than production)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you owe any debt or balance to any insurance company or financial services institution that has remained overdue for more than sixty (60) days? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has any state or federal agency ever denied, suspended, revoked, or taken any action against any fiduciary license held or applied for by you, or have you ever voluntarily submitted to any sanction or surrendered any fiduciary license under threat of suspension or revocation of that license? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has any state or federal self-regulatory body of any type (such as National Assn. of Securities Dealers) ever taken any disciplinary measures against you? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever had a claim filed against your Errors and Omissions Coverage, or has any bonding company ever denied, paid out on, or revoked a bond for you? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever been the subject of any civil or administrative proceeding, including one initiated by a state department of insurance? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have any felony charges pending against you, or have you ever pled guilty or nolo contendere to or been convicted of a felony or a crime involving moral turpitude? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have any unsatisfied liens (tax or otherwise) or judgments (civil or otherwise) against you? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you been the subject of a bankruptcy petition or proceeding in the past seven (7) years? | <input type="checkbox"/> | <input type="checkbox"/> |

(1) I hereby represent that the answers and statements ("the information") I am giving Golden Rule Insurance Company and its affiliates ("the Company") on this application ("PBA") are correct, complete, and wholly true. (2) I understand the Company will rely on the information as one factor in considering this PBA, and may, at its option, terminate or rescind our resulting business relationship if any of the information is not as I have given it. (3) I give the Company, its employees, agents, and/or contractors permission to direct advertising or promotional phone calls, faxes, and electronic mail to the numbers and addresses listed above, as well as any others I provide. This permission continues until specifically revoked by me in writing. (4) I understand this PBA will not be considered until I sign the FCRA Authorization.

Signature _____ Date _____

NOTE: No business may be solicited until all state licensing and appointment and/or requirements have been met, and you have been advised that fact in writing by the Company.

PROFILE INFORMATION

1. Over the past 12 months, what percentage of total revenue from your current insurance business does individual health represent? (Check one.)

- 0%-10% 11%-24 25%-49% 50% or more

2. What type of insurance is your primary line of business? (Check one.)

- | | | |
|--|--|--------------------------------|
| <input type="checkbox"/> Annuities/LTC | <input type="checkbox"/> Life | <input type="checkbox"/> Other |
| <input type="checkbox"/> Disability Income Insurance | <input type="checkbox"/> Medicare Business
(Part D, Supplement, etc.) | |
| <input type="checkbox"/> Financial Services | <input type="checkbox"/> Property/Casualty | |
| <input type="checkbox"/> Group Health | <input type="checkbox"/> Supplemental Policies
(Accident, Dental, Vision) | |
| <input type="checkbox"/> Individual Health | | |

3. How many new individual health applications did you personally write in the past 12 months with all carriers combined—excluding Short Term, Medicare Plans, Employer, and Employer/Group policies? (Check One.)

- | | |
|-------------------------------|----------------------------------|
| <input type="checkbox"/> 0 | <input type="checkbox"/> 21-50 |
| <input type="checkbox"/> 1-5 | <input type="checkbox"/> 51-100 |
| <input type="checkbox"/> 6-10 | <input type="checkbox"/> 101-200 |
| <input type="checkbox"/> 11-2 | <input type="checkbox"/> 201+ |

4. How many do you plan to write over the next 12 months? (Check one.)

- More
 Same
 Less

5. Which of the following carriers do you consider to be the primary and secondary recipients of your new individual health applications? Please mark your primary carrier with the number 1, and your secondary carrier with the number 2. Please mark 1 and 2 ONLY.

- | | | |
|---|---|---------------------|
| ___ Aetna | ___ Cigna | ___ Medical Mutual |
| ___ American Community | ___ Coventry/Health America | ___ PacifiCare |
| ___ American Medical Security | ___ Golden Rule/UnitedHealth One/UnitedHealthcare | ___ World Insurance |
| ___ Assurant/Fortis/Time | ___ Health Net | ___ Unicare |
| ___ Blue Cross Blue Shield/
Anthem/Wellpoint | ___ Humana One | ___ None |
| ___ Celtic | ___ Kaiser Permanente | ___ Other _____ |
| | ___ Mega Life and Health | |

6. Over the past 12 months, how many of the following products have you personally written?

Short Term Medical Plans

- 0
- 1-9
- 10-24
- 25+

Medicare Plans (Supplements, Advantage Plans or Part D)

- 0
- 1-9
- 10-24
- 25+

Health Savings Accounts (HSAs)

- 0
- 1-9
- 10-24
- 25+

Dental (standalone) Insurance Plans

- 0
- 1-9
- 10-24
- 25+

Accident (standalone) Insurance Plans

- 0
- 1-9
- 10-24
- 25+

Critical Illness (standalone) Insurance Plans

- 0
- 1-9
- 10-24
- 25+

7. How many states are you licensed in for health insurance?

- 1
- 2-4
- 5-9
- 10 or more

FAIR CREDIT REPORTING ACT DISCLOSURE and AUTHORIZATION

GOLDEN RULE INSURANCE COMPANY AND ITS AFFILIATED COMPANIES (“THE COMPANY”) MAY OBTAIN A CONSUMER REPORT ABOUT YOU IN CONNECTION WITH YOUR PROSPECTIVE BROKER APPLICATION (“PBA”).

AUTHORIZATION

I authorize the Company to conduct a public records search, and/or to obtain a consumer report and/or an investigative consumer report about me from a consumer reporting agency. These reports may concern my credit history, worthiness, standing, and/or capacity. These reports may also concern my character, general reputation, personal characteristics, criminal and civil history, and/or mode of living. I understand that the Company will use this information in whole or in part as a factor in considering my PBA.

I understand that if the Company decides not to approve my PBA, and thereby to take adverse action against me because of information contained in any consumer report(s) authorized by my signature on this form, the Company will provide to me:

- A written pre-adverse action disclosure;
- An adverse action notice;
- A copy of any consumer report(s) received and used by the Company;
- A copy of “A Summary of Your Rights Under the Fair Credit Reporting Act”;
- The name, address, and telephone number of any consumer-reporting agency that furnished a consumer report about me to them.

I understand that I am entitled to contest the accuracy or completeness of information contained in any consumer report. I understand that I am entitled to receive an additional free copy of any consumer report. I understand that the consumer reporting agency does not itself make any decision regarding my PBA, and the agency cannot explain the Company decision to me.

A photocopy or fax copy of this authorization shall be as effective as the original. This authorization remains valid until I revoke it in writing sent to the Company.

Printed Name	Social Security Number
Signature	Date
Home Address	
City, State and ZIP	

Golden Rule®

A UnitedHealthcare Company

FCRA-0306

ASSIGNMENT OF COMMISSIONS AND OTHER MONETARY COMPENSATION

To: Golden Rule Insurance Company and/or American Medical Security Life Insurance Company and/or PacifiCare Health Plan Administrators, Inc., and/or United Healthcare Insurance Company, and/or any affiliated company (collectively, "the Company").

If and when the Company owes me compensation because I have sold or secured the sale of insurance products of the Company or for any other reason, I (the undersigned "Assignor") do not wish to receive that compensation, but instead assign it to, and direct the Company to pay it to, the person or entity I have written below as Assignee per my applicability instructions below:

AHCP _____ **000005289** _____
Assignee Name (person/entity to be paid) Social Security/tax ID Number

4929 W Royal Ln 2nd Floor Irving TX 75063 _____
Street City State ZIP Phone

This Assignment applies to (select and complete **option 1 OR 2** below):

1. **All monetary compensation including commissions, monetary bonuses, monetary incentives/prizes.**
(in addition, check **one** box below)
 - all monetary compensation attributable to my business written **after** the date this form is processed by the Company
 - OR
 - all monetary compensation for all business issued, including any business issued prior to this date (only allowed if no prior Assignment has been submitted by the Assignor to the Company)
2. **Commissions only (monetary bonuses and monetary incentives/prizes will be paid directly to you)**
(in addition, check **one** box below)
 - all commissions attributable to my business written **after** the date this form is processed by the Company
 - OR
 - all first year and renewal commissions for all business issued, including any business issued prior to this date (only allowed if no prior Assignment has been submitted by the Assignor to the Company)

I understand and agree that:

1. Payments made by the Company pursuant to this Assignment fully discharge all of the Company's financial obligations to me under any compensation arrangement between us.
2. This Assignment is subject to, and does not affect, any terms or conditions of any such compensation arrangements except as specifically provided herein.
3. This Assignment is subject to applicable state and federal laws regarding assignment of commissions by insurance producers (by whatever name called). The Company will not be bound by this Assignment in any instance in which it believes applicable law prevents it from paying the Assignee, and it then may pay the person or entity that it, in its sole discretion, determines to be appropriate under the circumstances.
4. This Assignment shall remain in effect, and is binding on both myself and the Company, until revoked. I may revoke this Assignment by sending written notice to the Company. Such revocation will only apply to business written after the effective date of the revocation, and this Assignment will remain in effect for business written for the Company prior to that date. Revocation will be effective on the later of the date I request, or not later than thirty (30) days after the Company's receipt of the notice.
5. This Assignment does not apply to non-monetary incentives/prizes (e.g. merchandise, trips, non-cash incentives, awards, contest results, or any other non-cash remuneration).
6. Assignor understands the Assignee may enter into a Commission Advance Agreement ("Advance Agreement") with the Company. The Advance Agreement entitles the Assignee to receive an advance on the payment of compensation for business issued by the Company after the effective date of the Advance Agreement. Assignor understands and acknowledges that the Company, as a condition to agreeing to the Advance Agreement, requires the Assignee to obtain Assignments from all sub-brokers, including the Assignor. Assignor further agrees that commissions attributable to any business written by the Assignor that are advanced to the Assignee under their Advance Agreement are hereby assigned to the Assignor, even if the business was written prior to the date of this Assignment.

Assignor Signature

Date Signed

Assignor Printed Name
37835-G-0311

Social Security/ Tax ID Number

Sign and Return this Page to Golden Rule

INDEPENDENT BROKER'S CONTRACT SIGNATURE PAGE

I acknowledge and agree that:

- (a) I have received a copy of the Independent Broker's Contract Form (IBC-0410), consisting of this page and four (4) other pages, as well as the Rules and Regulations (Rules-0410), which are fully incorporated by reference and made a part of the *Contract*;
- (b) I have read, understood, and agreed to each and every term of this *Contract*; and
- (c) This *Contract* will not be in effect until such time as the *Company* has countersigned this Signature Page and attached the appropriate *Commission Schedule(s)*.

YOU:

Print or type *Your Name*

By:

Print Name (and title if signing in a representative capacity)

X

Signature

Date

BENEFICIARY DESIGNATIONS (See 3.9):	Name	Address	Relationship
Primary Beneficiary(ies):			
<hr/>			

Contingent Beneficiary(ies):

**FOR HOME OFFICE USE ONLY
EXECUTED ON BEHALF OF GOLDEN RULE INSURANCE COMPANY**

BY:

Name

X

Signature

Date

This agreement shall take effect as of _____ Producer No. _____

IBC-0410



Authorization for Automatic Deposit

This form will update account information associated to commissions processed by AHCP. To update direct deposit information for commissions processed by an insurance carrier you must complete the carriers direct deposit authorization form. Forms are located in the AHCP Forms Library.

Agent or Agency Name	
Social Security Number or Tax ID Number	
Phone Number	Email Address
Please indicate transaction type: <input type="checkbox"/> Set-Up <input type="checkbox"/> Change <input type="checkbox"/> Cancel	
Please indicate type of account: <input type="checkbox"/> Checking <input type="checkbox"/> Savings	
Name of Financial Institution:	
Bank—City, State, Phone Number:	
Routing Number:	
Account Number:	

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

Agent Signature _____ **Date** _____

PLEASE INCLUDE A COPY OF A VOIDED CHECK

Fax this form to AHCP– 972.915.3288
 Scanned versions of this form can be emailed to contracting@AHCPsales.com

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 (as shown on your income tax return)		
	Business name, if different from above		
	Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) <input type="checkbox"/> Other (see instructions)		<input type="checkbox"/> Exempt payee
	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. The TIN provided must match the name given on Line 1 to avoid backup withholding. 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 3. 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 3.

Note. If the account is in more than one name, see the chart on page 4 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. citizen or other U.S. person (defined below).

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 4.

Sign Here Signature of U.S. person

SIGN HERE
Date

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain 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 provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

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.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

PRODUCER AGREEMENT

This MARKETING AGREEMENT ("Agreement") is entered into by and between America's Health Care/Rx Plan AGENCY, Inc., a Delaware Corporation ("AHCP"), and _____, as Agent ("Agent"). The Agreement shall become effective upon Agent's licensure and appointment.

1. Appointment. AHCP appoints Agent to act as a marketer soliciting sales of products offered by and through AHCP and its authorized Carriers. "Carrier" means any insurance company or membership association with whom AHCP has entered into a master marketing agreement.

2. Relationship and Authority. The relationship of Agent to AHCP and scope of authority are set forth in the Agent Guidelines. Agent and Sub-Agents must be properly licensed and approved and appointed by AHCP. "Sub-Agent" means a person or entity that has executed a Producer Agreement with AHCP. Sub-Agents may be solicited by Agent or assigned to Agent by AHCP. Once the Sub-Agent's paperwork has been submitted and approved by AHCP, the Sub-Agent will be enrolled with all AHCP Carriers under the Agent. A Sub-Agent may not sell products from different AHCP Carriers under different Agents. Agent agrees to comply with the liability insurance requirements set forth in the Agent Guidelines. Agent shall be solely responsible for paying all expenses incurred by Agent in performance of this Agreement, including all license fees, appointment fees, bond fees, and fees and taxes required by any federal, state or local government. A Sub-Agent may submit a written request to AHCP to be transferred to another Agent if (1) the Sub-Agent has not sold business for at least six-months; and (2) has no outstanding balance with AHCP. If the Agent has sold business, they must obtain a written release from their current Agent. If the Sub-Agent has an outstanding debit balance, the new Agent must agree to assume liability for the balance before the transfer will be approved.

3. Commissions. Subject to all terms of the Agreement, AHCP or its delegate will compensate Agent with the commissions as determined by each Carrier. AHCP does not impose a vesting schedule on Agent. Agent is immediately vested per each Carrier's requirements. AHCP will use reasonable efforts to provide vesting information from Carriers to Agent. Confirmation of 1st year and renewal percentages shall be made available to Agent upon written request to AHCP. Commissions may be modified by AHCP with in ten (10) days notice to Agent as set forth in Agent Guidelines. Commissions paid to Agent will be net of any commissions paid to the Sub-Agent. AHCP reserves the right to approve all commission percentages to Sub-Agents, which approval shall not be unreasonably withheld. No commission shall be deemed earned until the policy or membership agreement is issued, delivered, and accepted by the applicant. Commissions will not be paid until AHCP collects or receives payment of its commission.

4. Advance Commissions/Debit Balances. AHCP or Carriers on AHCP's behalf may, at its discretion, make advances to Agent in anticipation of future commissions subject to the rules set forth in Agent Guidelines. Such advances will create debit balances, which both parties expressly agree are loans from AHCP. In consideration for the advance commissions, Agent agrees to repay to AHCP or their assigns, the debit balances and interest. AHCP reserves the right to charge interest on all debit balances. Agent is financially responsible to AHCP and their assigns, for any and all debit balances due by Agent, any Sub-Agent, or any Sub-Agent from which Agent receives an override. Agent and Sub-Agents shall assume the full and complete advance balance and debit balance of any Sub-Agent. In the event of a transfer of an Agent from one manager to another, debit balance will transfer to the new manager who agrees to assume financial responsibility for repayment. Coincident with that transfer, all rights to any future earned commissions attributable to the account, and tax benefits, will also be transferred to Agent. Agent shall submit to financial audits and will confirm debit balances upon written request from AHCP. **Agent expressly agrees to be bound by all rules and conditions set forth in Agent Guidelines.**

5. Carrier Requirements. Agent will comply with all Carrier requirements, including providing information or executing forms. Failure to comply may result in forfeiture of commissions and appointment by Carrier.

6. Termination. This Agreement may be terminated without cause by either party upon thirty (30) days written notice. AHCP may terminate immediately "for cause" (as defined in Agent Guidelines) with written notice to Agent. If this Agreement is terminated for cause, then all of Agent's rights to any compensation shall be immediately terminated. Upon termination of this Agreement, AHCP may reassign, solicit, appoint or otherwise work with the Sub-Agents of Agent.

7. Exclusivity. During the term of the Agreement, AHCP should be the primary supplier of all products to be promoted and sold by Agent and Sub-Agents. Agent may be licensed with other insurance companies to sell other product lines. However, Agent may not recruit AHCP Agents to sell product lines of other insurance companies.

ADDENDUM A
ASSIGNMENT OF COMMISSIONS AGREEMENT

AHCP agrees to provide Agents with the following benefits and services:

- Lead Marketing Credits for each issued policy where applicable (varies by product)
- Incentive trip credits
- Free Replicated Website
- Training program, web conferences, and training materials
- Marketing Materials for proprietary products
- Advances funded by AHCP
- Toll free agent service line
- Weekly newsletter that includes all Carrier updates in one place in addition to important announcements and weekly agent rankings

In exchange for access to AHCP programs and services, Agent agrees to the assignment to AHCP of all commissions earned, subject to the following terms and conditions:

1. All earned commissions assigned to and received by AHCP are received on the Agent's behalf and will promptly be paid out in its entirety to the Agent pursuant to the commission structure and advance commission agreement between AHCP and the Agent. All commission payments will be made by AHCP or its delegate.
2. Agent may, upon written notice to AHCP, opt out of receiving any advance commissions. AHCP will pay out to Agent all earned commissions.
3. AHCP reserves the right to modify commission or advance commission agreements by providing 10 days advance written notice to Agent.
4. Agent expressly acknowledges that advance commissions from AHCP may result in debit balances being owed by Agent to AHCP. Agent understands that these debit balances are loans which are tied to Agent and must be repaid to AHCP. If AHCP determines that monthly commissions will not satisfy the debit balance within 10 months, AHCP may, upon written notice to Agent, use Agent's commissions from any AHCP Carrier to reduce any debit balances.
5. AHCP may not assign commissions to any unaffiliated party without Agent's express written consent.
6. This assignment only applies to commissions for AHCP business while this agreement is in effect. Subject to use of commissions to repay debit balances owed, AHCP shall retain no interest in or control of business sold by Agent. AHCP expressly acknowledges that this agreement in no way changes or affects the Agent's status as "Agent of Record" for any business for which commissions have been assigned to AHCP.
7. This assignment may be revoked by Agent upon 30 days written notice to AHCP and the Carrier. Once revoked, Agent will be entitled to receive commissions from Carrier so long as all debit balances with AHCP have been paid.
8. AHCP does not impose a vesting schedule on Agent. Agent is immediately vested per each Carrier's requirements. AHCP will use reasonable efforts to provide vesting information from Carriers to Agent.

Agent Signature

Date