AGENT INFORMATION

Legal Name: _____
Last First MI

Address: _____
Street Address Apartment/ Unit #

_____
City State Zip Code

Home Phone: _____ Business Phone: _____

Email Address: _____

SSN: _____ Tax ID: _____ Date of Birth: _____

UPLINE & COMMISSION

Direct Up-line/ Manager: _____ DP: _____

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

How did you hear about AHCP?

☐Online ☐Job Posting ☐Drip Marketing ☐Referral _____
(Name of Referral)

Advance Options: ☐Earned Commission

APPOINTMENT INSTRUCTIONS

Appointment Checklist for: **American National**

- ☐Page 1 AHCP Appointment Coversheet (this page)
- ☐Page 2-3 Agent Agreement
- ☐Page 4 Confidential Questionnaire
- ☐Page 5-7 HIPAA BAA Contract
- ☐Page 8 Direct Deposit Authorization Form (Commissions Paid by AHCP)
- ☐Page 9 W9
- ☐Page 10-13 AHCP Producer Agreement

Additional Requirements

- ☐Copy of Licenses
- ☐Copy of E&O Insurance Certificate
- ☐Supporting documentation for any "Yes" answers to background questions

RETURN INSTRUCTIONS

Scan Email Option: Send to contracting@ahcpsales.com
Fax Option: 888-781-0586
Mailing Address: 1100 NW Compton Dr. 2nd Floor Beaverton, OR 97006

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.

AMERICAN NATIONAL

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**

SIGN HERE

_____

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**_____ SIGN HERE

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 _____

AHCP
America's Health Care Plan

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: [ ] Set-Up [ ] Change [ ] Cancel	
Please indicate type of account: [ ] Checking [ ] 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– 888.781.0586
Scanned versions of this form can be emailed to contracting@AHCPsales.com

Form **W-9**
(Rev. December 2011)
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 (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:
☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶

☐ Other (see instructions) ▶

☐ 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 the "Name" line 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

			–		–				

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 ▶** **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.

AHCP
America's Health Care Plan

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 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 percentage shall be made available to Agent upon written request to AHCP. Commissions may be modified by AHCP within 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 percentage 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 received 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 crease 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 with 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 right 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.

8. Premiums. Agent shall immediately remit all premiums collected or received by Agent and its Sub-Agents in accordance will the guidelines of AHCP. Initial premium may be presented with the application to be accepted by AHCP or Carrier.

9. Rolling Business. AHCP acknowledges that Agent must act in the client's best interest when recommending changes of carriers. However, Agents agrees that the moving of a block of business to another carrier, for the sole purpose of generating or increasing commissions, is not permitted by AHCP.

10. Records**.** Agent shall keep records and provide reports as set forth in Agent Guidelines. AHCP or Carrier will furnish Agent with a monthly statement of Agent's account and will pay any amounts due, subject to other provisions of the Agreement. Agent must report any discrepancies and return payment without 30 days or payment will be deemed accepted.

11. Printed Material. AHCP will furnish all printed matter necessary for doing business under the Agreement. Agent and Sub-Agents will not use any materials referring to AHCP or Carriers without first securing written approval. All printed materials furnished are property of AHCP and shall be promptly returned upon request or when Agreement terminates.

12. Refunds and Rejections. Subject to state law, Carrier reserves the right to reject any applications for insurance without specifying cause, and to cancel, refuse to renew, or modify and policy. In such cases, all premiums will be refunded.

13. Discontinuance of Policy Forms. Without incurring any liability, AHCP or Carrier may discontinue, replace, or withdraw any policy. AHCP or Carrier may also determine commissions and renewal commissions on any policy not scheduled herein.

14. Proprietary Information. Agent agrees to fully comply with all requirements set forth in Agent Guidelines.

15. Indemnity. Agent agrees to indemnify AHCP, Carrier, affiliates, shareholders, directors, officers, and employees and to hold them harmless from all expenses, liabilities, cost, causes of action, loss, damage, and expense, including attorney's fees and costs of litigation, resulting from any breach of the Agreement or unauthorized, negligent or wrongful act, omission, statement, or presentation by Agent, Agent's employees and Sub-Agents.

16. Assignment. AHCP may assign its rights to a third party. Agent may not, without the express prior written consent of AHCP, assign any of its rights, responsibilities or commissions. AHCP will have a superior, continuing security interest in all commissions prior to the right of any permitted assignee. Any assignment so authorized shall be subject to any and all indebtedness of Agent to AHCP then existing or thereafter accruing.

17. Security Interest. To secure the payment of any indebtedness and performance of Agent of all terms of the Agreement, Agent agrees to assign commissions to AHCP pursuant to the terms set forth in Addendum A.

18. Applicable Law. The Agreement shall be governed by the laws of Texas with exclusive venue in Tarrant County, Texas.

19. Partial Invalidity. If any provision of this Agreement is declared invalid for any reason, the invalidity of that provision shall not affect the validity of any other provision of this Agreement.

20. Entire Agreement. This Agreement, including Addendum A in the Agent Guidelines, constitutes the entire agreement and supersedes and replaces any and all prior written or oral agreement between these parties. This Agreement may not be modified without written consent of both parties and shall be binding upon the successors and heirs of the parties hereto.

Executed as the _____ day of _____ 20____.

By: _____ _____
Agent's Signature Print Name

By:
Aaron Goddard, Vice President
America's Health Care/RX Plan Agency, Inc.

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 conference, 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 b AHCP are received on the Agent's behalf and will promptly be paid out in its entirety to the Agent pursuant to the commissions 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 to providing 10 days advance written notice to Agent.

4. Agent expressly acknowledges that advance commission 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 commission 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 Carriers 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 Carrier's requirements. AHCP will use reasonable efforts to provide vesting information from Carriers to Agent.

_____ _____

Agent Signature Date