



AHCP
America's Health Care Plan

Discover the
DIFFERENCE
with AHCP



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: **Anthem IN/OH**

- Page 1 AHCP Appointment Coversheet (this page)
- Page 2-4 Producer Appointment Data Sheet
- Page 5 Medicare Advantage Signature Authorization
- Page 6 Direct Deposit Authorization (Commissions paid by AHCP)
- Page 7 W9
- Page 8-11 AHCP Producer Agreement

Additional Requirements

- Copy of Licenses
- Copy of Voided Check
- 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

Rev.072414

Producer Appointment Data Sheet

Red border indicates required field.

SECTION 1: PRODUCER INFORMATION

First name	M.I.	Last name	Suffix	Social Security no./Government ID no.	
Date of birth (MM/DD/YYYY)	National producer no. (NPN optional)		Home phone no.		Home fax no. (optional)
Producer business phone no. Ext.			Producer business fax no.		
Residence mailing address (no PO Box)		City	State	ZIP code	County
Business mailing address (if PO Box, please provide physical address below)		City	State	ZIP code	County
Physical location business mailing address (if different from business address)		City	State	ZIP code	County

I prefer to receive mailings at: Residence mailing address Business mailing address Physical location business mailing address

Business email address

Are you bilingual? Yes No If Yes, what language(s) do you speak? _____

Previous names or aliases

Have you used any other names or aliases in the last seven (7) years? Yes No If Yes, please list any/all such names.

Different first and/or last name?	Previous name
<input type="checkbox"/> First <input type="checkbox"/> Last	
<input type="checkbox"/> First <input type="checkbox"/> Last	
<input type="checkbox"/> First <input type="checkbox"/> Last	

SECTION 2: APPOINTMENT INFORMATION

Type of appointment Subagent Firm/agency Agent
 Is firm/agency incorporated? Yes No
 If Yes, type of corporation: Sole proprietor LLC LLP S-Corporation

All Exchange business must be submitted under the same assignment. If this is your only assignment, this will be your Exchange relationship. CA, CO, NV, GA and NY allow more than one assignment at a time. CT, IN, KY, ME, MO, NH, OH, VA and WI allow only one assignment at a time. Do you authorize for this to be your Exchange relationship on this new assignment?

Yes No

SECTION 3: COMMISSION ASSIGNMENT – Complete this section if commissions are to be assigned to an agency or corporation

Agency name	Agency tax ID no.	Agency principal name			
Agency business address	City	State	ZIP code	County	
Agency physical location address (no PO box)	City	State	ZIP code	County	
County	Agency fax no.				

SECTION 4: COMMISSION HIERARCHY – If applicable

Brokerage general agency (BGA) name N/A	BGA broker ID no. or BGA broker code N/A
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SECTION 5: PREVIOUS ADDRESSES

Have you lived anywhere other than the above mentioned legal residence in the last two (2) years? Yes No
 If Yes, please list any/all such addresses. Please enter any additional information in the Remarks (section 10).

Previous address	City	State	ZIP code	County
Previous address	City	State	ZIP code	County

SECTION 6: EMPLOYMENT HISTORY

Have you been employed anywhere other than with your current employer in the last two (2) years? Yes No
 If Yes, please list any/all such employment history. Please enter any additional information in the Remarks section (section 10).

Previous employer name	Start date	End date
Previous employer address	City	State ZIP code
Previous employer name	Start date	End date
Previous employer address	City	State ZIP code

SECTION 7: LICENSE INFORMATION

Residence license state	Residence license no.

SECTION 8: E&O POLICY INFORMATION — Please include a copy of your declaration page or certificate with application

Policy amount	Policy no.	Policy carrier	Effective date	Expiration date

SECTION 9: BUSINESS PRACTICES

If you answer "Yes" to any questions, attach a signed written explanation with all relevant information and supporting documents.

a. Have you ever had an insurance license or appointment, or a securities registration, or an application for such, denied, suspended, canceled or revoked?	<input type="checkbox"/> Yes <input type="checkbox"/> No	g. Have you individually, or has a company you exercised control over, filed a bankruptcy petition or been the subject of an involuntary bankruptcy petition?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Has any legal or regulatory body ever sanctioned, censured, penalized or otherwise disciplined you?	<input type="checkbox"/> Yes <input type="checkbox"/> No	h. Are there any unsatisfied judgments, garnishments, or liens against you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Has any state or federal regulatory agency or self-regulatory authority ever filed a complaint against you?	<input type="checkbox"/> Yes <input type="checkbox"/> No	i. Are you in debt to any insurance company?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Have you ever been subjected to an insurance or investment related, consumer initiated complaint or proceeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No	j. Have you ever been indicted for, convicted of, or pled guilty or nolo contendere to any felony or misdemeanor other than a minor traffic offense?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Has a bonding or surety company denied, ever paid out on, or revoked a bond for you?	<input type="checkbox"/> Yes <input type="checkbox"/> No	k. Are you currently party to any litigation or the subject of any investigations?	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Has an E&O carrier ever denied claims, paid claims, or canceled your coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No	l. Has any employer, insurance company, or securities, broker-dealer ever terminated your employment or contract, or permitted you to resign for any other reason than lack of sales?	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 10: REMARKS — Enter any remarks or additional information from sections 5, 6 and/or 7. Attach additional sheets, if necessary.

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SECTION 11: AUTHORIZATION – Signature required

This notice is being provided to you by the Company pursuant to the Fair Credit Reporting Act (“FCRA”). As used herein, “the Company” means the identified insurer (the insurer identified on this form) and its subsidiaries, affiliates, officers, employees, agents, and representatives.

In connection with determining your eligibility for an insurance agent or producer license and/or your eligibility to be appointed or sponsored as an agent of the Company, and to maintain such license and appointment, in one or more states, the Company will from time to time conduct background checks. Such background checks may include the ordering of “consumer reports” from a “consumer reporting agency” containing information on your criminal and credit history. These terms are defined in the FCRA.

I acknowledge and agree that this Producer Appointment Data Sheet does not constitute a contract of any kind. I hereby authorize the Company and its authorized agents to investigate my background, references, character, past employment, education, criminal or police reports, including those mandated by both public and private organizations and all public records for the purpose of qualifications for my appointment, I hereby consent to the Producer Appointment Form and background information to government or regulatory agencies.

I hereby release the Company, its authorized agents and any person or entity which provides information pursuant to this authorization, from any and all liabilities, claims or lawsuits relating to the information obtained from any and all of the above referenced sources, or from the furnishing of the same. This is a continuing authorization.

I understand that I am obligated to immediately report any event that changes any of the information, in any manner, which I have provided on this application.

I hereby certify that all of the information herein is accurate and complete. Finally, I acknowledge and agree that my appointment will, in part, be based on this Producer Appointment Data Sheet and background information, and any falsification, misrepresentation or omission of information from this form may result in the withholding or withdrawal of any offer of appointment or the revocation of appointment by the Company whenever discovered.

For Maine Applicants Only

Upon request, you will be informed whether or not an investigative consumer report was requested, and if such a report was requested, the name and address of the consumer reporting agency furnishing the report. You may request and receive from us, within five business days of our receipt of your request, the name, address and telephone number of the nearest unit designated to handle inquiries for the consumer reporting agency issuing an investigative consumer report concerning you. You also have the right, under Maine law, to request and promptly receive from all such agencies copies of any reports.

For New York Applicants Only

You have the right, upon written request, to be informed of whether or not a consumer report was requested. If a consumer report is requested, you will be provided with the name and address of the consumer reporting agency furnishing the report.

I understand that I may sign this Acknowledgement and Authorization for Appointment manually or by electronic signature. Further, I understand that whether I sign manually or by electronic signature, the signature will have a legally binding effect on me or the agency on whose behalf I am signing.

I certify that I have read and understand the above information.

Signature X	Date (MM/DD/YYYY)
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Privacy Policy: Your privacy is important to us. We do not sell or share any personal information contained in this document with any third parties, with exception of providing information to state or government agencies for the express use of obtaining licenses or licensing information. We reserve the right to disclose your personally identifiable information as required by law and/or to comply with a judicial proceeding, court order, or legal process served on our company. We shall not be held responsible for any personal information obtained illegally by a third party via fax, email, or other online transmittal.

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company, Inc. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), which underwrites or administers the PPO and indemnity policies; CompCare Health Services Insurance Corporation (CompCare), which underwrites or administers the HMO policies; and CompCare and BCBSWI collectively, which underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

IN WITNESS WHEREOF, the parties have executed this Agreement to be effective for the term set forth herein.

“PRODUCER”

(Print Full Name of Producer)

By: _____
(Signature of Authorized Signatory)

Name: _____
(Print Name of Signatory)

Title: _____
(Print Title of Signatory)

“CUSTOMER”

Anthem Insurance Companies, Inc.

By: 

Erin Ackenheil
Vice President
Medicare Sales

Producer Writing # (Tax ID#) Agency tax ID# (if appl) Social Security #

Business Address (Street, City, State, Zip) Email Address

Producer Phone # Producer Fax #

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado and Nevada: Rocky Mountain Hospital and Medical Service, Inc. In Connecticut: Anthem Health Plans, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. In Ohio: Community Insurance Company. In Virginia (excluding the City of Fairfax, the Town of Vienna and the area east of State Route 123.): Anthem Health Plans of Virginia, Inc. In Wisconsin: Blue Cross Blue Shield of Wisconsin ("BCBSWi"), which underwrites or administers the PPO and indemnity policies; CompCare Health Services Insurance Corporation ("CompCare"), which underwrites or administers the HMO policies; and CompCare and BCBSWi collectively, which underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.



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— 888.781.0586
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/disregarded entity name, if different from above	
	Check appropriate box for federal tax classification: <input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S 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 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.

Social security number									

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

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 ▶
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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.



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 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 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 with 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.

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