



**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:     3 Month     6 Month     9 Month     Earned Commission

*\*No interest (Advance options will have a 3% admin fee)*

### APPOINTMENT INSTRUCTIONS

Appointment Checklist for: **Assurant (Online Appointment)**

- Page 1    AHCP Appointment Coversheet (this page)
- Page 2-3    Prospective Broker Application
- Page 4    Assurant State Appointment Fees
- Page 5    Direct Deposit Authorization (Commissions paid by AHCP)
- Page 6    W9
- Page 7-10    AHCP Producer Agreement

**\*AHCP will complete the online appointment for you within 24-48 hours of receiving the attached paperwork. Once Assurant receives the completed online contract, it may take up to 20 business days to process due to background checks. If there are additional requirements missing, AHCP will reach out to you.**

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](mailto:contracting@ahcpsales.com)

**Fax Option:** 888-781-0586

**Mailing Address:** 1100 NW Compton Dr. 2<sup>nd</sup> Floor Beaverton, OR 97006



AGENCY INFORMATION

1. MGA Name: MGA Business No.  
America's HealthCare/Rx Plan Agency, Inc. (AHCP) 000B4000193001  
2. GA Name: GA Business No.  
America's HealthCare/Rx Plan Agency, Inc. (AHCP) 000431FB193001

INDIVIDUAL AGENT INFORMATION

4. Agent's Name (Full legal name): Nickname (Optional):  
5. Social Security Number: 6. Date of Birth:  
7. Resident Address: (Required)

STREET CITY / STATE / ZIP (9 DIGIT) PHONE

8. Business Address: (Optional)

STREET or P.O. BOX CITY / STATE / ZIP (9 DIGIT)

|        |  |     |  |
|--------|--|-----|--|
| PHONE  |  | FAX |  |
| E-MAIL |  |     |  |

9. License Requirements – We in which you intend to operate where permitted. Please send \_\_\_\_\_ nt state account

10. Are you now or have you ever used any name other than shown above?  Yes  No If yes, list names, dates and reason used: \_\_\_\_\_

11. Have you ever been appointed with Time Insurance Company (previously known as Fortis Insurance Company?)  
 Yes  No If yes, list agent numbers: \_\_\_\_\_

12. Name of Errors and Omissions Carrier: \_\_\_\_\_  
If you do not have E&O, you can purchase coverage through Assurant.

Provide details to any "YES" answers for questions 13 – 15 on an attached sheet.

13. Have you ever had a professional license refused, revoked or suspended; or, has disciplinary action been taken against you by a regulatory agency?  Yes  No

14. Are you currently indebted to any insurance company or agency, or is there any dispute regarding your insurance accounts?  Yes  No

15. Have you ever pled guilty or no contest or been convicted of any violation of law other than minor traffic violations?  Yes  No

Products are underwritten and issued by:

Time Insurance Company  
501 W Michigan  
Milwaukee, WI 53201

**16. List your residence address for past five years up to and including present date:**

| FROM<br>(MO / YR) | TO<br>(MO / YR) | ADDRESS | CITY / STATE / ZIP | PHONE |
|-------------------|-----------------|---------|--------------------|-------|
|                   |                 |         |                    |       |
|                   |                 |         |                    |       |
|                   |                 |         |                    |       |

**17. List all employers for past five years up to and including present date. Include dates, addresses, and positions:**

| FROM<br>(MO / YR) | TO<br>(MO / YR) | ADDRESS | CITY / STATE / ZIP | PHONE |
|-------------------|-----------------|---------|--------------------|-------|
|                   |                 |         |                    |       |
|                   |                 |         |                    |       |
|                   |                 |         |                    |       |

**IMPORTANT INFORMATION**

**Fair Credit Act --** I hereby authorize and request any present or former employer, police department, financial institution, insurance company, department of insurance or other persons having personal knowledge about me, to furnish bearer with any and all information in their possession regarding me in connection with an application for appointment as an insurance agent. I am willing that a photocopy of this authorization be accepted with the same authority as the original, and I specifically waive any written notice from any present or former employer who may provide information based upon this authorized request. I understand this authorization is to be part of the written agent application which I signed and applies to all companies, including any affiliated or import companies with which Assurant Health has a relationship, and products I may sell through that application.

**Taxpayer Identification --**Internal Revenue Code Section 6109 requires us to obtain your correct Federal Taxpayer Identification Number (TIN). This information is required so that payments can be accurately reported to you on Form 1099-MISC. Failure to provide us with correct information may subject your account to backup withholding. If this occurs, we must withhold and pay to the Internal Revenue Service 31% of certain payments made to your account.

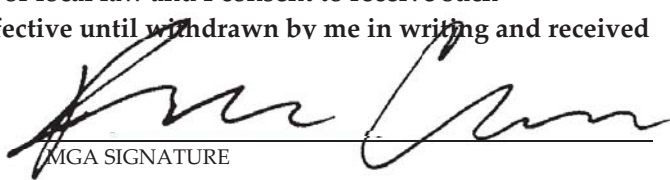
**Please Note:**

This application cannot be processed unless all questions have been answered and appropriate license copies are attached. Fees associated with appointments will be charged to your commission account where permitted.

**I represent that the answers given in this application are true and correct to the best of my knowledge and belief. I understand that any misrepresentations or misstatements may result in immediate cancellation of this appointment and the accompanying sales agreement. I grant full authorization to Time Insurance Company, Assurant Health and affiliated companies to communicate with me via fax, e-mail or any other electronic means at the numbers/address I have provided herein or at any number/address I subsequently provide to Time Insurance Company. I understand that such communications may qualify as advertisements under federal, state or local law and I consent to receive such advertisements. This authorization and permission shall remain effective until withdrawn by me in writing and received by Time Insurance Company.**

AGENT'S SIGNATURE

DATE



MGA SIGNATURE

**Company Use Only**

Appointment Date

Agent Business No.

Products are underwritten and issued by:

**Time Insurance Company**

501 W Michigan  
Milwaukee, WI 53201

# ASSURANT STATE APPOINTMENT FEES



| State                 | Resident Fee | Non-Resident Fee            | Cancellation Fee | Renewal Fee  |
|-----------------------|--------------|-----------------------------|------------------|--------------|
| <b>*Alabama</b>       | \$30         | \$30                        |                  | \$10         |
| Alaska                | no fee       | no fee                      | no fee           | no fee       |
| Arizona               | no fee       | no fee                      | no fee           | no fee       |
| <b>*Arkansas</b>      | company pays | company pays                | company pays     | company pays |
| California            | \$22         | \$22                        | \$22             |              |
| Colorado              | no fee       | no fee                      | no fee           | no fee       |
| Conneticut            | \$80         | \$80                        |                  | \$80         |
| Deleware              | \$25         | \$25                        |                  | \$0          |
| DC                    | \$25         | \$25                        |                  | \$25         |
| Florida               | \$61.98      | \$61.98 (\$6.60 per county) |                  | \$61.98      |
|                       |              | 1                           |                  | 1            |
|                       |              | 2                           |                  | 2            |
|                       |              | 3                           |                  | 3            |
|                       |              | 4                           |                  | 4            |
|                       |              | 5                           |                  | 5            |
| <b>*Georgia</b>       | \$10         | \$10                        |                  | \$10         |
| Hawaii                | no fee       | no fee                      | no fee           | no fee       |
| Idaho                 | no fee       | no fee                      | no fee           | no fee       |
| Illinoise             | no fee       | no fee                      | no fee           | no fee       |
| Indiana               | no fee       | no fee                      | no fee           | no fee       |
| Iowa                  | \$50         | \$50                        |                  | \$50         |
| Kansas                | \$5          | \$5                         |                  | \$5          |
| Kentucky (agent)      | \$40         | \$50                        |                  | \$40/\$50    |
| Kentucky (agency)     | \$100        | \$120                       |                  | \$100/\$120  |
| Louisiana             | \$20         | \$20                        |                  | \$20         |
| Maine                 | \$30         | \$70                        |                  | \$30         |
| Maryland              | no fee       | no fee                      | no fee           | no fee       |
| Massachusetts         | \$75         | \$75                        |                  | \$75         |
| Michigan              | \$5          | \$5                         |                  | \$5          |
| Minnesota             | \$10         | \$10                        |                  |              |
| <b>*Mississippi</b>   | \$25         | \$25                        |                  | \$25         |
| Missouri              | no fee       | no fee                      | no fee           | no fee       |
| Montana               | no fee       | no fee                      | no fee           | no fee       |
| Nebraska              | \$24         | \$24                        | \$3              | \$24         |
| Nevada                | \$15         | \$15                        |                  | \$15         |
| New Hampshire         | \$25         | \$25                        | \$25             |              |
| New Jersey            | \$25         | \$25                        | \$25             | \$25         |
| New Mexico            | \$20         | \$20                        |                  | \$20         |
| North Carolina        | \$20         | \$20                        | \$20             | \$20         |
| North Dakota          | \$10         | \$10                        |                  | \$10         |
| Ohio                  | \$20         | \$20                        | \$5              | \$20         |
| <b>*Oklahoma</b>      | \$55         | \$55                        |                  | \$55         |
| Oregon                | no fee       | no fee                      | no fee           | no fee       |
| Pennsylvania          | \$15         | \$15                        |                  | \$15         |
| Rhode Island          | no fee       | no fee                      | no fee           | no fee       |
| South Carolina        | company pays | company pays                | company pays     | company pays |
| South Dakota          | \$10         | \$20                        |                  | \$10/\$20    |
| Tennessee             | \$15         | \$15                        | \$15             |              |
| Texas                 | \$10         | \$10                        |                  |              |
| Utah                  | no fee       | no fee                      | no fee           | no fee       |
| Vermont               | \$70         | \$70                        |                  | \$70         |
| Virginia              | \$12         | \$12                        |                  | \$12         |
| Washinton             | \$20         | \$20                        |                  | \$20         |
| <b>*West Virginia</b> | \$25         | \$25                        |                  | \$25         |
| Wisconsin             | \$16         | \$50                        |                  | \$16/\$50    |
| <b>*Wyoming</b>       | \$15         | \$15                        | \$15             | \$15         |

**\* State Requires Background Check**

## CREDIT CARD AUTHORIZATION

AGENT NAME

NAME ON CARD (if different)

CARD TYPE

CREDIT CARD NUMBER

EXPIRATION DATE

CARD SECURITY CODE

The CSC number is a 3 digit number located in the signature block on the back of most cards. AMEX is 4 digits located on the front.

TOTAL AUTHORIZED CHARGE

By providing the above information and by signing below, I hereby authorize AHCP to charge my credit card for payment purposes specified above.

SIGNATURE OF AUTHORIZATION

DATE



### 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:<br><input type="checkbox"/> Set-Up <input type="checkbox"/> Change <input type="checkbox"/> Cancel |               |
| Please indicate type of account:<br><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**

## Request for Taxpayer Identification Number and Certification

**Give Form to the  
 requester. Do not  
 send to the IRS.**

|                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                         |
|-------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|
| <b>Print or type<br/>See Specific<br/>Instructions on page 2.</b> | Name (as shown on your income tax return)                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |
|                                                                   | Business name/disregarded entity name, if different from above                                                                                                                                                                                                                                                                                                                                                                                                                           |                                         |
|                                                                   | Check appropriate box for federal tax classification:<br><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<br><br><input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____<br><br><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.

|                  |                            |        |
|------------------|----------------------------|--------|
| <b>Sign Here</b> | 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.



## 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.




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 by 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