



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: Advanced Earned

*3 month advance on 6 month term and 6 month advance on 12 month term

APPOINTMENT INSTRUCTIONS

Appointment Checklist for: **Health Insurance Innovations**

- Page 1 AHCP Appointment Coversheet (this page)
- Page 2-4 HII Agent Contract
- Page 5-12 Companion Life
- Page 13 Direct Deposit Authorization (Commissions paid by AHCP)
- Page 14 W9
- Page 15-18 AHCP Producer Agreement

***An online contract is also required for Freedom LM and AME. AHCP will be completing the online portion for 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

Fax Option: 888-781-0586

Mailing Address: 1100 NW Compton Dr. 2nd Floor Beaverton, OR 97006

Rev.071714



HEALTH INSURANCE INNOVATIONS (HII) SUB-AGENT INFORMATION FORM

COMPLETE THE FOLLOWING INFORMATION ABOUT YOURSELF:

Agent Name _____ Date of Birth _____ Social Security# _____
 Corporation/Agency Name _____ Tax I.D.* _____ Email _____
 Business Street Address _____ City _____ St. _____ Zip _____
 Resident Street Address _____ City _____ St. _____ Zip _____
 Business Telephone # (_____) _____ Fax # (_____) _____ Resident Telephone # (_____) _____

** If HII is to pay Marketing Fees/ Commissions to an Agency or Corporation and you are not the Owner / Officer, you must sign the assignment below, and we must have another License Request Form completed by the Agency Owner / Officer; as well as copies of his or her license. Include the Agency's license if applicable in your state.*

ANSWER THE FOLLOWING QUESTIONS:

1. Have you ever been convicted of a felony? YES NO
2. Have you ever been involved in an investigation with any State Insurance Department? YES NO
3. Has your license ever been suspended, cancelled, or revoked by any State Insurance Department? YES NO
4. Have you ever filed Bankruptcy, been sued or had a judgment entered against you? YES NO

Any "YES" answer above requires a separate statement, including dates, location, basis of charge and legal documentation indicating disposition of case.

1. Do you carry errors and omissions coverage? YES NO (If YES, list carrier name and limits) _____
2. What lines of insurance are you licensed to sell: Life Accident / Health Other _____
3. Please list the state(s) where you hold a license: State ____ License # _____; State ____ License # _____; State ____ License # _____

Attach copies of your resident and all nonresident licenses. (HII does not require an appointment fee.)

ASSIGNMENT OF MARKETING FEES / COMMISSIONS REQUEST:

Only complete the following if authorizing HII to pay your Marketing Fees/ Commissions to a Corp., Agency, or another Agent.

I, _____ Agent Code # _____, hereby assign to Assignee: _____ all of my right, title, and interest in Marketing Fees and/or renewals to which I am now entitled or become entitled, under existing contracts and agreements, heretofore entered into by and between myself and HII I hereby authorize and empower HII, to pay assignee all Marketing Fees and renewals now due or which may accrue under said contracts, for a period of one year from this date and thereafter until such time as I terminate this assignment by written notice to HII. I agree that such payments of Marketing Fees under my contract are the same as if payment was made directly to me. I hereby covenant and agree that I am the absolute and sole owner of said Marketing Fees, free from prior assignment or any encumbrance of any kind or character whatsoever, and that I have full right and lawful authority to sell and transfer the same as aforesaid.

Witness my hand this _____ day of _____, Year _____, Agent's Signature _____ SIGN HERE

CAUTION: The person assigning his or her Marketing Fees (assignor) will not recover the right to receive any further Marketing Fees during the one-year period from the date of this assignment unless and until the person to whom such rights are assigned (assignee) releases, in writing, his or her rights to receive such Marketing Fees. Please be certain you understand this before signing the form. This instrument may be revoked, in writing, by the Assignor at any time after the one-year period.

Address of Assignee: _____ Tax I.D. # _____

STATEMENT OF UNDERSTANDING:

This Statement of Understanding must be signed to be in effect and is between undersigned Agent and Health Insurance Innovations, herein referred to HII. HII agrees to pay Marketing Fees / Commissions on the plans listed on the attached Addendum in accordance with, and subject to, the conditions and covenants below.

- The term "monthly plan cost and paid" shall mean monies, excluding any enrollment fee, monthly administrative fee or association dues, due and paid for the plan after the effective date of this Agreement by each member and for whom the Agent is the representative of record.
- Marketing Fees / Commissions shall be payable only when Agent is (a) properly approved to transact business for HII and (b) is continuously recognized by HII as the Agent of Record to receive said Marketing Fees / Commissions.
- This Agreement may be terminated by either party with a 30 day written notice but only with respect to new cases. Such terminations will have no effect on the payment of Marketing Fees / Commissions on business written prior to the effective date of termination as may otherwise be payable.
- No advertising material (on paper, over the radio or television or on the Internet) bearing HII or our product name or describing any named product distributed by HII can be produced without prior written approval from HII.
- The Agent is an independent contractor, not an employee of HII.
- The Agent has no authority to act on behalf of HII, bind coverage, waive, or alter any provision of the application or the Product under which membership is issued.
- Representations and opinions of the Agent are not binding on HII plans.
- By signing below, I grant HII prior written express invitation and permission to transmit facsimile and email advertisements to me.
- Ensure compliance with the Federal Trade Commission's Telemarketing Sales Rule, including, but not limited to Local, State, and Federal laws promulgated pursuant to the Telephone Consumer Protection Act (TCPA).
- Support DNC Manager (can be the Agent) in:
 - managing, updating, and maintaining the internal Do Not Call list
 - implement and disseminate internal DNC policy and procedures to all entity staff
 - obtaining certification from each entity supplying leads to verify that supplied leads have been checked against the National and applicable State registries
 - ensuring purchased or agency-generated leads are not obtained via pre-recorded solicitation calls without the express, written consent of the persons being called, regardless of whether said persons are or are not on the Do Not Call registry
 - scrubbing leads if the lead supplier does not certify that they were checked against the National and applicable State registries.
 - checking all supplied/purchased leads against the National, State, Local, and Internal DNC lists prior to distributing list for solicitation.
 - Placing telephone calls to any telephone number on the applicable Internal, Local, State or National DNC registry, outside of exceptions listed in the registries' policies and procedures.
 - Ensure all Agent's staff, including full-time, part-time and 1099 employees receive, review and document receipt of the Agent's DNC policy and procedures. • Written documentation of receipt and understanding of Agent's DNC policy is required to be kept on file in each staff members' file & reconfirmed every six months.

READ CAREFULLY BEFORE SIGNING:

The above information is true and complete. I understand false statements on this form may be sufficient cause for termination. I have read the Statement of Understanding and understand that if these guidelines are not followed, the result will be termination of this Agreement.

Agent Signature: _____  Date: _____ Title: _____

Sub-AGN Name: _____ HII Code #: _____ GA/MGA Name: _____ HII Code #: _____

Recruited By: _____

Mail your completed required forms and a copy of your current license(s) to your GA or MGA.

Agent Profile Form

<i>Last Name</i>			<i>First Name</i>			<i>Middle</i>									
<i>Social Security Number</i>			<i>Gender</i>		<i>DOB</i>		<i>US Citizen</i>								
<i>Agency Name</i>					<i>Tax ID#</i>										
<i>Resident Address</i>					<i>City</i>		<i>State</i>	<i>Zip</i>							
<i>Business Address</i>					<i>City</i>		<i>State</i>	<i>Zip</i>							
<i>Business Phone</i>			<i>Cell Phone</i>			<i>Fax Number</i>									
<i>Email</i>					<i>Website</i>										
<i>Preferred Mailing Address</i>			<i>Business</i>			<i>Resident</i>									
<p><i>Please check off the states below, in which you will be representing HII. Please provide a current copy of insurance license(s) for each state checked. We also need a copy / proof of your E&O insurance.</i></p> <p><i>If assigning commissions to an agency or corporation, please also provide a copy of the agency license (if applicable).</i></p>															
<input type="checkbox"/>	AL	<input type="checkbox"/>	AK	<input type="checkbox"/>	AZ	<input type="checkbox"/>	AR	<input type="checkbox"/>	CA	<input type="checkbox"/>	CO	<input type="checkbox"/>	CT	<input type="checkbox"/>	DE
<input type="checkbox"/>	DC	<input type="checkbox"/>	FL	<input type="checkbox"/>	GA	<input type="checkbox"/>	HI	<input type="checkbox"/>	ID	<input type="checkbox"/>	IL	<input type="checkbox"/>	IN	<input type="checkbox"/>	IA
<input type="checkbox"/>	KS	<input type="checkbox"/>	KY	<input type="checkbox"/>	LA	<input type="checkbox"/>	ME	<input type="checkbox"/>	MD	<input type="checkbox"/>	MA	<input type="checkbox"/>	MI	<input type="checkbox"/>	MN
<input type="checkbox"/>	MS	<input type="checkbox"/>	MO	<input type="checkbox"/>	MT	<input type="checkbox"/>	NE	<input type="checkbox"/>	NV	<input type="checkbox"/>	NH	<input type="checkbox"/>	NJ	<input type="checkbox"/>	NM
<input type="checkbox"/>	NY	<input type="checkbox"/>	NC	<input type="checkbox"/>	ND	<input type="checkbox"/>	OH	<input type="checkbox"/>	OK	<input type="checkbox"/>	OR	<input type="checkbox"/>	PA	<input type="checkbox"/>	RI
<input type="checkbox"/>	SC	<input type="checkbox"/>	SD	<input type="checkbox"/>	TN	<input type="checkbox"/>	TX	<input type="checkbox"/>	UT	<input type="checkbox"/>	VT	<input type="checkbox"/>	VA	<input type="checkbox"/>	WA
<input type="checkbox"/>	WV	<input type="checkbox"/>	WI	<input type="checkbox"/>	WY	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
<p>Notice Regarding Background Checks</p> <p><i>Before our company may begin processing your appointment and/or license application, we are required by *federal law to ensure that all agents and/or employees we wish to do business with are not convicted criminals or felons. *(Criminal checks are based on the Violent Crime Control Act of 1994)</i></p> <p><i>We will notify you if your background report results are unfavorable and we consequently decline your license appointment. In addition, you will be advised to discontinue submission of business to our company and/or service to any of our clients as well. In the event that the information reflected in the criminal report is incorrect, we will advise you of the protocol to appeal.</i></p>															

Additional Information required to sell the Freedom Access Membership:

Drivers Licence Number: _____ **State Issued:** _____

Married: _____ **If YES, please list spouse's name:** _____

Last five years of employment: (list dates, company name and position with company)

APPOINTMENT CONTRACT

INSTRUCTIONS TO BECOME APPOINTED & CONTRACTED WITH COMPANION LIFE INSURANCE COMPANY:

1. All information **must be** filled in and this form signed and dated before it can be approved and processed.
2. Attach a photocopy of your current Producer license for all states to be appointed.
3. If Commissions are being paid to an agency, please attach a photocopy of Agency License.
4. If commissions are to be paid to an agency, give Agency Name _____
and Tax ID No: _____.

Mr. Ms. Mrs.

LAST NAME: _____ FIRST NAME: _____

MIDDLE NAME: _____ NICKNAME: _____

BUSINESS OVERNIGHT MAILING ADDRESS:

(STREET) (CITY) (STATE) (ZIP)

EMAIL ADDRESS: _____

BUSINESS PHONE: _____ FAX NUMBER: _____

HOME ADDRESS:

(STREET) (CITY) (STATE) (ZIP)

COUNTY: _____

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____

NATIONAL PRODUCER NUMBER: _____

SEND CORRESPONDENCE TO: BUSINESS ADDRESS (OR) HOME ADDRESS

YES NO

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been convicted of, or currently charged with, any felony involving dishonesty or breach of trust? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been convicted of, or currently charged with, committing a crime involving moral turpitude since becoming licensed? |
| <input type="checkbox"/> | <input type="checkbox"/> | With the exception of credit life and disability insurance agents, are you employed by or associated with any degree, directly or indirectly, a financial institution as defined in section 626.988, F.S.? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been convicted of any crime under the Violent Crime Control and Law Enforcement Act of 1994 (18 United States Code, §§1033 and 1034)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have an outstanding debt with any insurance company? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been bankrupt or insolvent, either personally or professionally? |
| <input type="checkbox"/> | <input type="checkbox"/> | Has an insurance company ever canceled a contract with you for any reason other than lack of production? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a complaint filed against you by a state or provincial insurance department? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had an insurance license denied or revoked by a state or province? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been refused a surety or fidelity bond? |

If the answer to any of these questions is "yes," please provide details on a separate sheet of paper.

By my signature below, I hereby certify that I have reviewed this application and the information contained herein is wholly true, correct and complete to the best of my knowledge and belief. I understand that Companion Life Insurance Company, and or its affiliates or assignees, hereinafter called (the "COMPANY") may conduct information searches to verify the information contained in this application. If any information given to obtain or maintain an appointment is found to be incorrect or incomplete, it will be grounds for rejecting this application or for termination of my appointment at the sole discretion of the COMPANY. The COMPANY retains sole authority to terminate any appointment subject to applicable laws and regulations.

All applicants and appointed agents must comply with all insurance laws, regulations and insurance department bulletins in the jurisdictions in which appointed. The applicant may not use, distribute, or publish any advertisements (as defined by the laws of the jurisdictions for which the applicant is appointed), solicit materials, or proposal, until all state licensing and appointment and/or contract requirements are met, and you have been advised by the COMPANY. Following applicant's notification of the approved appointment by COMPANY, appointed agent may not use, distribute, or publish any advertisements (as defined by the laws of the jurisdictions for which the applicant is appointed), solicit materials, or proposal which has not been filed with and approved in writing by COMPANY. The applicant and approved agent shall not use COMPANY service or trademarks without the prior written consent of COMPANY. The applicant and appointed agent hereby agree to assist and cooperate with COMPANY regarding any and all insurance department inquiries, complaints or investigations.

FAIR CREDIT REPORTING ACT DISCLOSURE

When considering your application for appointment, when making a decision whether to execute an appointment, when deciding whether to continue your appointment (if you are appointed), and when making other appointment related decisions directly affecting you, the COMPANY may obtain and use a "consumer report" from a "consumer reporting agency." These terms are defined in the Fair Credit Reporting Act (FCRA), which applies to you. As an applicant for agent appointment, you are a "consumer" with rights under the FCRA. A "consumer report" is any written, oral or other communication of any information by a "consumer reporting agency" bearing on a consumer's character, general reputation, personal characteristics or mode of living. You may also contact the Federal Trade Commission about your rights under the FCRA as a "consumer" with regard to "consumer reports" and "consumer reporting agencies." You have a right to make a written request, with a reasonable period of time, to receive information about the nature and scope of this investigation.

SIGN HERE

DATE

AGENT SIGNATURE

DATE APPROVED

COMPANION LIFE INSURANCE COMPANY

*SUMMARY OF PRODUCER APPOINTMENT REQUIREMENTS FOR CURRENTLY LICENSED PRODUCERS				
PRE-APPOINTED STATES				
Georgia (GA)	Montanta (MT)	North Carolina (NC)	Pennsylvania (PA)	Washington (WA)
Kansas (KS)		Louisiana (LA)		
NO PRE-APPOINTMENT REQUIREMENTS				
Alabama (AL)	Alaska (AK)	Arkansas (AR)	Arizona (AZ)	California (CA)
Colorado (CO)	Connecticut (CT)	Delaware (DE)	District of Columbia (DC)	Florida (FL)
Hawaii (HI)	Illinois (IL)	Idaho (ID)	Indiana (IN)	Iowa (IA)
Kentucky (KY)	Maine (ME)	Maryland (MD)	Massachusetts (MA)	Michigan (MI)
Minnesota (MN)	Mississippi (MS)	Missouri (MO)	Nebraska (NE)	Nevada (NV)
New Hampshire (NH)	New Jersey (NJ)	New Mexico (NM)	New York (NY)	North Dakota (ND)
Ohio (OH)	Oklahoma (OK)	Oregon (OR)	Rhode Island (RI)	South Carolina (SC)
South Dakota (SD)	Tennessee (TN)	Texas (TX)	Utah (UT)	Vermont (VT)
Virginia (VA)	West Virginia (WV)	Wisconsin (WI)	Wyoming (WY)	



AGREEMENT WITH BUSINESS ASSOCIATE

This Agreement (“BAA”) is effective upon execution, and is made by and between **the undersigned Agent/Agency** (“Business Associate”) and Companion Life Insurance Company (“Company”).

Company and Business Associate mutually agree to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and its implementing regulations (45 C.F.R. Parts 160-64) and the requirements of the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 (the “HITECH Act”), that are applicable to business associates, along with any guidance and/or regulations issued by DHHS. Company and Business Associate agree to incorporate into this Agreement any regulations issued with respect to the HITECH Act that relate to the obligations of business associates. Business Associate recognizes and agrees that it is obligated by law to meet the applicable provisions of the HITECH Act.

A. Privacy & Security of Protected Health Information and Electronic Protected Health Information.

1. **Permitted Uses and Disclosures.** Business Associate is permitted or required to use or disclose Protected Health Information (“PHI”) and electronic PHI it creates or receives for or from Company or to request PHI and electronic PHI on Company’s behalf only as follows:
 - a) **Functions and Activities on Company’s Behalf.** To perform functions, activities, services, and operations on behalf of Company, consistent with HIPAA, the HITECH Act, and their implementing regulations as specified in the Producer Appointment Agreement.
 - b) **Business Associate’s Operations.** Business Associate may use the Minimum Necessary PHI and electronic PHI for Business Associate’s proper management and administration or to carry out Business Associate’s legal responsibilities. Business Associate may disclose the Minimum Necessary PHI and electronic PHI for Business Associate’s proper management and administration or to carry out Business Associate’s legal responsibilities only if:
 - (i) The disclosure is required by law; or
 - (ii) Business Associate obtains reasonable assurance, evidenced by written contract, from any person or organization to which Business Associate will disclose PHI or electronic PHI that the person or organization will:
 - a. Hold such PHI, electronic PHI in confidence and use or further disclose it only for the purpose for which Business Associate disclosed it to the person or organization or as Required by Law; and
 - b. Promptly notify Business Associate (who will in turn promptly notify Company) of any instance of which the person or organization becomes aware in which the confidentiality of such PHI or electronic PHI was breached.
2. **Minimum Necessary and Limited Data Set.** Business Associate’s use, disclosure or request of Protected Health Information shall utilize a Limited Data Set if practicable. Otherwise, Business Associate will, in its performance of the functions, activities, services, and operations specified in Section A.1(a) above, make reasonable efforts to use, to disclose, and to request of a Covered Entity only the minimum amount of Company’s Protected Health Information reasonably necessary to accomplish the intended purpose of the use, disclosure or request.
3. **Prohibition on Unauthorized Use or Disclosure.** Business Associate will neither use nor disclose PHI or electronic PHI except as permitted or required by this Agreement, as otherwise permitted in writing by Company, or as required by law. This Agreement does not authorize Business Associate to use or disclose PHI or electronic PHI in a manner that would violate the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. Parts 160-64) or the HITECH Act and its implementing regulations, if done by Company, except as set forth in Section A(1)(b).
4. **Sale of PHI:** Business Associate shall not directly or indirectly receive remuneration in exchange for PHI except where permitted by the Agreement and consistent with applicable law.
5. **Marketing:** Business Associate shall not directly or indirectly receive payment for any use or disclosure of PHI for marketing purposes except where permitted by the Agreement and consistent with applicable law.

6. **Fundraising:** Business Associate shall not use or disclose PHI for fundraising purposes except where permitted by the Agreement and consistent with applicable law.
7. **Genetic Information:** Business Associate shall not use or disclose genetic information to the extent prohibited by 45 C.F.R. § 164.502(a)(5)(i).
8. To the extent that Company and Business Associate agree that Business Associate is to carry out Company's or its clients' obligations under 45 C.F.R. Part 164, Subpart E (the Privacy Rule), Business Associate shall comply with the requirements of the Privacy Rule that apply to Company or its clients in the performance of such obligation. In addition, Business Associate shall comply with the applicable requirements of 45 C.F.R. Part 164, Subpart C. This provision shall not be interpreted to limit the generality of any other provision of this Agreement.
9. **Information Safeguards.** Business Associate will develop, document, implement, maintain, and use appropriate administrative, technical, and physical safeguards, in compliance with Social Security Act § 1173(d) (42 U.S.C. § 1320d-2(d)), 45 C.F.R. Part 164, Subparts C & E, and any other implementing regulations issued by the U.S. Department of Health and Human Services (including, but not limited to, CMS Core Security Requirements, if applicable), and any other applicable laws. The safeguards will be designed to preserve the integrity, availability and confidentiality of electronic PHI, and to prevent intentional or unintentional non-permitted or violating use or disclosure of, PHI. Business Associate will additionally develop any safeguards to the extent required by the HITECH Act. Business Associate will document and keep these safeguards current. Business Associate agrees to mitigate any harmful effect that is known to the Business Associate resulting from a use or disclosure of PHI or electronic PHI by the Business Associate or its subcontractors in violation of the requirements of this Agreement.
10. **Subcontractors and Agents.** Business Associate will require any of its subcontractors and agents, to which Business Associate is permitted by this Agreement or in writing by Company to disclose PHI and electronic PHI, to provide reasonable assurance, evidenced by written contract, that such subcontractor or agent will comply with the same privacy and security obligations as Business Associate with respect to such PHI and, electronic PHI.

B. Compliance with Standard Transactions. If Business Associate conducts, in whole or part, Standard Transactions for or on behalf of Company, Business Associate will comply, and will require any subcontractor or agent involved with the conduct of such Standard Transactions to comply, with each applicable requirement of 45 C.F.R. Part 162. Business Associate will not enter into, or permit its subcontractors or agents to enter into, any Trading Partner Agreement in connection with the conduct of Standard Transactions for or on behalf of Company that:

1. Changes the definition, data condition, or use of a data element or segment in a Standard Transaction;
2. Adds any data element or segment to the maximum defined data set;
3. Uses any code or data element that is marked "not used" in the Standard Transaction's implementation specification or is not in the Standard Transaction's implementation specification; or
4. Changes the meaning or intent of the Standard Transaction's implementation specification.

C. Individual Rights.

1. **Access.** Business Associate will, within five (5) business days after Company's request, make available to Company or, at Company's direction, to the individual (or the individual's personal representative) for inspection and obtaining copies any PHI and electronic PHI about the individual that is in Business Associate's custody or control, so that Company may meet its access obligations under 45 C.F.R. § 164.524 and, where applicable, the HITECH Act. Business Associate shall make such information available in an electronic format where directed by Company.
2. **Amendment.** Business Associate will, upon receipt of notice from Company, promptly amend or permit Company access to amend any portion of the PHI and electronic PHI, so that Company may meet its amendment obligations under 45 C.F.R. § 164.526.
3. **Disclosure Accounting.** So that Company may meet its disclosure accounting obligations under 45 C.F.R. § 164.528:
 - a) **Disclosure Tracking.** Business Associate will record information concerning each disclosure of PHI or electronic PHI, not excepted from disclosure tracking under Agreement Section C.3(b) below, that Business Associate makes to Company or a third party. The Disclosure Information Business Associate will record includes: (i) the disclosure date; (ii) the name and (if known) address of the person or entity to whom Business

Associate made the disclosure; (iii) a brief description of the PHI or electronic PHI disclosed; and (iv) a brief statement of the purpose of the disclosure (items i-iv, collectively, the "disclosure information"). Business Associate further shall provide any additional information to the extent required by the HITECH Act and any accompanying regulations. For repetitive disclosures Business Associate makes to the same person or entity for a single purpose, Business Associate may provide (x) the disclosure information for the first of these repetitive disclosures; (y) the frequency, periodicity or number of these repetitive disclosures; and (z) the date of the last of these repetitive disclosures.

Business Associate will make this disclosure information available to Company within ten (10) business days after Company's request.

- b) **Exceptions from Disclosure Tracking.** Business Associate need not record disclosure information or otherwise account for disclosures of PHI or electronic PHI that this Agreement or Company in writing permits or requires (i) for purposes of Treating the individual who is the subject of the PHI or electronic PHI disclosed, payment for that Treatment, or for the Health Care Operations of Company or Business Associate (except where such recording or accounting is required by the HITECH Act, and as of the effective dates for this provision of the HITECH Act); (ii) to the individual who is the subject of the PHI or electronic PHI disclosed or to that individual's personal representative; (iii) pursuant to a valid authorization by the person who is the subject of the PHI or electronic PHI disclosed; (iv) to persons involved in that individual's health care or Payment related to that individual's health care; (v) for notification for disaster relief purposes; (vi) for national security or intelligence purposes; (vii) as part of a Limited Data Set; or (viii) to law enforcement officials or correctional institutions regarding inmates or other persons in lawful custody.
 - c) **Disclosure Tracking Time Periods.** Unless otherwise provided under the HITECH Act, Business Associate must have available for Company the disclosure information required by Agreement Section C.3(a) for the six (6) years preceding Company's request for the disclosure information. In addition, where Business Associate is contacted directly by an individual based on information provided to the individual by Company, and where so required by the HITECH Act and/or any accompanying regulations, Business Associate shall make such Disclosure Information available directly to the individual.
4. **Restriction Requests; Confidential Communications.** Business Associate shall immediately notify Company's Privacy Officer of any individual request made pursuant to 45 C.F.R. § 164.522 that Company or Business Associate restrict the disclosure of protected health information of the individual. Business Associate will comply with any requests for restriction requests and confidential communications of which it is aware and to which Company agrees pursuant to 45 C.F.R. § 164.522 (a) and (b).
5. **Inspection of Books and Records.** Business Associate will make its internal practices, books, and records, relating to its use and disclosure of PHI or electronic PHI, available to Company and to the U.S. Department of Health and Human Services to determine compliance with 45 C.F.R. Parts 160-64 or this Agreement.

D. Breach of Privacy & Security Obligations.

1. **Breach.** Business Associate will report to Company any use or disclosure of PHI or electronic PHI not permitted by this Agreement or by Company in writing. Business Associate will make the report to Company's Privacy Officer within three (3) business days after Business Associate knew or by the exercise of reasonable diligence should have known of such non-permitted use or disclosure. In addition, Business Associate will report, following discovery and without unreasonable delay, but in no event later than three (3) business days following discovery, any "Breach" of "Unsecured Protected Health Information" as these terms are defined by the HITECH Act and any implementing regulations, even if Business Associate deems the unauthorized acquisition, access or use to be in good faith, unintentional or inadvertent and even if Business Associate deems the risk of harm posed to the individuals involved to be insignificant. Business Associate shall cooperate with Company in investigating the Breach and in meeting the Company's obligations under the HITECH Act and any other security breach notification laws.

Any such report shall include the identification (if known) of each individual whose Unsecured Protected Health Information has been, or is reasonably believed by Business Associate to have been, accessed, acquired, or disclosed during such Breach. Business Associate's report will, at a minimum:

- a) Identify the nature of the non-permitted access, use or disclosure, including the date of the Breach and the date of discovery of the Breach;
- b) Identify the PHI or electronic PHI accessed, used or disclosed as part of the Breach (e.g. full name, social security number, date of birth, etc.);

- c) Identify who made the non-permitted or violating access, use or disclosure and who received the non-permitted disclosure;
 - d) Identify what corrective action Business Associate took or will take to prevent further non-permitted access, uses or disclosures;
 - e) Identify what Business Associate did or will do to mitigate any deleterious effect of the non-permitted access, use or disclosure; and
 - f) Provide such other information, including a written report, as Company may reasonably request.
2. **Security Incident.** Business Associate will additionally report to Company as requested by the Company any attempted or successful (a) unauthorized access, use, disclosure, modification, or destruction of Company's electronic PHI of which Business Associate becomes aware, or (b) interference with system operations in Business Associate's Information System containing Company's electronic PHI ("Security Incident") of which Business Associate becomes aware. If the Security Incident resulted in an unauthorized access, use, or disclosure, then a written report shall be provided according to the timeline and content requirements in Section D.1 above.
3. **Mitigation.** Business Associate agrees to mitigate, to the extent practicable, any harmful effect resulting from any Breach or attempted or successful Security Incident. In addition, Business Associate shall cooperate with and implement any reasonable mitigation requests by Company relating to any Breach or attempted or successful Security Incident. Any mitigation performed pursuant to this Section shall be done at Business Associate's expense.

E. General Provisions.

1. Termination of Agreement.

a) Right to Terminate for Breach.

- (i) Company may terminate Agreement if it determines, in its sole discretion, that Business Associate has breached any provision of this Agreement. Company may exercise this right to terminate Agreement by providing Business Associate written notice of termination, stating the breach of the Agreement that provides the basis for the termination. Any such termination will be effective immediately or at such other date specified in Company's notice of termination. If for any reason Company determines that Business Associate has breached the terms of this Agreement and such breach has not been cured, but Company determines that termination of the Agreement is not feasible, Company may report such breach to the U.S. Department of Health and Human Services.
- (ii) Business Associate may terminate Agreement if it determines, after reasonable consulting with Company, that Company has breached any material provision of this Agreement and upon written notice to Company of the breach, Company fails to cure the breach within thirty (30) days after receipt of the notice. Business Associate may exercise this right to terminate Agreement by providing Company written notice of termination, stating the failure to cure the breach of this Agreement that provides the basis for the termination. Any such termination will be effective upon such reasonable date as the parties mutually agree. If Business Associate reasonably determined that Company has breached a material provision of this Agreement and such breach has not been cured, but Business Associate and Company mutually determine that termination of the Agreement is not feasible, Business Associate may report such breach to the U.S. Department of Health and Human Services.

b) Obligations upon Termination.

- (i) **Return or Destruction.** Upon termination, cancellation, expiration or other conclusion of Agreement, Business Associate will, if feasible, return to Company or destroy all PHI and electronic PHI in whatever form or medium (including any electronic medium) and all copies of any data or compilations derived from and allowing identification of any individual who is a subject of PHI and electronic PHI. Company will determine, in its sole discretion, whether Business Associate will destroy or return such PHI and electronic PHI. Business Associate will complete such return or destruction as promptly as possible, but not later than ten (10) business days after the effective date of the termination, cancellation, expiration or other conclusion of Agreement. All costs related to the Business Associate's return or destruction of PHI and electronic PHI will be paid by the Business Associate. Business Associate will identify any PHI and electronic PHI that cannot feasibly be returned to Company or destroyed. Business Associate will limit its further use or disclosure of that PHI and electronic PHI to those purposes that make return or destruction of that PHI and electronic PHI infeasible. Within ten (10) business days after the effective date of the

termination, cancellation, expiration or other conclusion of Agreement, Business Associate will (a) certify on oath in writing to Company that such return or destruction has been completed, (b) deliver to Company the identification of any PHI and electronic PHI for which return or destruction is infeasible, and (c) certify that it will only use or disclose such PHI and electronic PHI for those purposes that make return or destruction infeasible.

- (ii) **Continuing Privacy Obligation.** Business Associate's obligation to protect the privacy of the PHI and electronic PHI it created or received for or from Company will be continuous and survive termination, cancellation, expiration or other conclusion of Agreement.
 - c) **Other Obligations and Rights.** Business Associate's other obligations and rights and Company's obligations and rights upon termination, cancellation, expiration or other conclusion of Agreement will be those set out in the Agreement.
2. **Indemnity.** Each party (the "Indemnifying Party") will indemnify and hold harmless the other (the "Indemnified Party") and any Indemnified Party affiliate, officer, director, employee or agent from and against any reasonable expenses, including, without limitation, judgments, settlements, penalties, assessments, reasonable attorney's fees and costs, incurred as a direct result of a third-party claim arising out of or in connection with a breach of this Agreement by the Indemnifying Party or any subcontractor, agent, person or entity under the Indemnifying Party's control. . This duty of indemnity is contingent upon the Indemnified Party giving the Indemnifying Party the following: (a) prompt notice of the third-party claim; (b) an opportunity to exercise sole control over the defense and/or settlement of the third-party claim, provided that the Indemnifying Party shall secure the Indemnified Party's advance, written consent to any settlement; and (c) reasonable assistance in the defense and/or settlement of the third-party claim
3. **Definitions.** With respect to any information created, received, maintained, or transmitted by Business Associate from or on behalf of Company or another business associate of Company ("Company Information"), the following definitions apply:
- a) The capitalized terms "Covered Entity," "Electronic Protected Health Information ("electronic PHI" or "ePHI" shall be construed to be "Electronic Protected Health Information"), "Protected Health Information" ("PHI" shall be construed to be "Protected Health Information"), "Standard," "Trading Partner Agreement," and "Transaction" have the meanings set out in 45 C.F.R. § 160.103.
 - b) The term "Standard Transactions" shall have the meaning set out in 45 C.F.R. § 162.103. The term "Minimum Necessary" shall have the meaning set out in 45 C.F.R. § 164.502.
 - c) The term "Required by Law" has the meaning set out in 45 C.F.R. § 164.103.
 - d) The terms "Health Care Operations," "Payment," "Research," and "Treatment" have the meanings set out in 45 C.F.R. § 164.501.
 - e) The term "Limited Data Set" has the meaning set out in 45 C.F.R. § 164.514(e). The term "use" means, with respect to PHI, utilization, employment, examination, analysis or application within Business Associate.
 - f) The terms "disclose" and "disclosure" mean, with respect to PHI, release, transfer, providing access to or divulging to a person or entity not within Business Associate.
 - g) Any other capitalized terms not identified here shall have the meaning as set forth in 45 Code of Federal Regulations ("C.F.R.") Parts 160-64 for the Administrative Simplification provisions of Title II, Subtitle F of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), or in the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 (the "HITECH Act").
4. **Owner of Protected Health Information.** Company is the exclusive owner of PHI and electronic PHI generated or used under the terms of the Agreement or this Agreement.
5. **Amendment to Agreement.** Upon the effective date of any final regulation or amendment to final regulations promulgated by the U.S. Department of Health and Human Services with respect to PHI, electronic PHI or Standard Transactions, this Agreement will automatically amend such that the obligations they impose on Business Associate remain in compliance with these regulations.
6. **Disclosure of De-identified Data.** The process of converting PHI or electronic PHI to De-identified Data ("DID") is set forth in 45 C.F.R. § 164.514. In the event that Company provides Business Associate with DID, Business

Associate shall not be given access to, nor shall Business Associate attempt to develop on its own, any keys or codes that can be used to re-identify data.

7. **Creation of De-identified Data.** In the event Business Associate wishes to convert PHI or electronic PHI to DID, it must first subject its proposed plan for accomplishing the conversion to Company for Company's approval, which shall not be unreasonably withheld.
8. **Intent.** The parties agree that there are no intended third party beneficiaries under this Agreement.
9. **Business Associate Guidance.** Business Associate shall comply with any reasonable written policy, procedure or guidance concerning access to PHI for healthcare operations (as that term is defined in 45 C.F.R. Part 164) that is given by Companion Life Insurance Company to Business Associate.

IN WITNESS WHEREOF, Company and Business Associate execute this Agreement in multiple originals to be effective on the last date written below.

[Agency or Agent Name]
Print Agency/Agent Name

Companion Life Insurance Company

By: _____



By: _____

Printed Name: _____

Printed Name: Trescott N. Hinton, Jr.

SSN: _____

Title: President

Title: _____

Date: _____

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: <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— 1 8 0 0 8 1 5 2 1 1
 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 [REDACTED], 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.

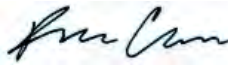
18. Applicable Law. The Agreement shall be governed by the laws of Texas with exclusive venue in Tarrant County, Texas.

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 [redacted] day of [redacted] 20 [redacted].

By: [redacted] [redacted]
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