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

*No interest (Advance options will have a 3% admin fee) *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)
- ☐Pages 2-4 HII Agent Contract
- ☐Page 5-8 Markel Insurance Company
- ☐Page 9-15 Companion Life
- ☐Page 16-18 Star Indemnity & Liability Company
- ☐Page 19 Direct Deposit Authorization (Commissions paid by AHCP)
- ☐Page 20 W9
- ☐Page 21-24 AHCP Producer Agreement

Additional Requirements

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

RETURN INSTRUCTIONS

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

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 Southampton 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 PA 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: AHCP ST20000000 _____ 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 a s 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_____

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: 1100 NW Compton Dr. 2nd Floor Beaverton, OR 97006 _____ Tax I.D .# 02-0690863 _____

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: AHCP HII Code #: ST20000000

Recruited By: Scott Lingle

Mail your completed required forms and a copy of your current license(s) to your GA or MGA.
If none is listed, fax the completed, signed documents to 1-877-376-5832, or
you can mail the forms to Health Insurance Innovations, 14501 N. Florida Ave., Suite 201, Tampa, FL 33613

Agent Profile Form

Last Name	*First Name*	*Middle*

Social Security Number	*Gender*	*DOB*	*US Citizen*

Agency Name	*Tax ID#*

Resident Address	*City*	*State*	*Zip*

Business Address	*City*	*State*	*Zip*

Business Phone	*Cell Phone*	*Fax Number*

Email	*Website*

Preferred Mailing Address ☐ *Business* ☐ *Resident*

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.

If assigning commissions to an agency or corporation, please also provide a copy of the agency license (if applicable).

☐	AL	☐	AK	☐	AZ	☐	AR	☐	CA	☐	CO	☐	CT	☐	DE
☐	DC	☐	FL	☐	GA	☐	HI	☐	ID	☐	IL	☐	IN	☐	IA
☐	KS	☐	KY	☐	LA	☐	ME	☐	MD	☐	MA	☐	MI	☐	MN
☐	MS	☐	MO	☐	MT	☐	NE	☐	NV	☐	NH	☐	NJ	☐	NM
☐	NY	☐	NC	☐	ND	☐	OH	☐	OK	☐	OR	☐	PA	☐	RI
☐	SC	☐	SD	☐	TN	☐	TX	☐	UT	☐	VT	☐	VA	☐	WA
☐	WV	☐	WI	☐	WY	☐		☐		☐		☐		☐	

Notice Regarding Background Checks

*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)*

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.

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 employement: (list dates, company name and position with company)

_____

Fax or Mail to: Health Insurance Innovations Fax: 877.376.5832
Mailing Address: 218 E. Bearss Ave., Suite 325, Tampa, Florida 33613 APF0806

LIFE, ANNUITY AND HEALTH PRODUCER APPOINTMENT FORM

(NAME OF INSURANCE COMPANY MUST BE INSERTED BEFORE THIS FORM IS USED)

Markel Insurance Company

1. FORM PURPOSE ☐ New Appointment ☐ Change ☐ Termination Appointment ☐ Additional Appointment

2. PRODUCER INFORMATION

First Name:

Middle Name:

Last Name:

Designations:

Legal Residence (No P.O. Box) Preferred Mailing ☐
Line 1:

Line 2:

City: State: Zip: –

Date of Birth (mm/dd/yyyy) | SSN # / Gov't ID

National Producer Number

Business Name:

Business Address Preferred Mailing ☐
Line 1:

Line 2:

City: State: Zip: –

FEIN

Business Phone
( ) - Extension

Business Fax
( ) -

Website Address

Business e-mail Address

Have you used any other names or aliases? If "YES", please list any/all such names.

Previous Names

PREFIX	FIRST NAME	MIDDLE NAME	SURNAME	SUFFIX	NAME TYPE (Check One) ALIAS	MAIDEN	PREVIOUS
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐

3. BROKER / DEALER INFORMATION (This section is only applicable if you are a Broker / Dealer).

Broker / Dealer Name:

Broker / Dealer Address
Line 1:

Line 2:

City: State: Zip: –

Tax ID #:

Phone #:

Fax #:

Broker / Dealer CRD #:

4. APPOINTMENT INFORMATION

Type of Appointment ☐ Individual ☐ Firm / Agency

Is Firm / Agency Incorporated? ☐ Yes ☐ No

If incorporated, indicate type of corporation: ☐ Sole Proprietor ☐ LLC ☐ S-Corporation ☐ LLP

5. COMMISSION HIERARCHY (If Applicable)

Brokerage General Agency (BGA) Name:

BGA Number:

General Agent: AHCP ST20000000

Agency Name:

6. EMPLOYMENT HISTORY

Have you been employed anywhere other than with your current employer in the last seven (7) years?
If "YES", please list any/all such employment history. For additional information please use Remarks section.

Current Employer Name:

Current Employer Address
Line 1:

Line 2:

City: State: Zip: –

Start Date:

Previous Employer Name:

Previous Employer Address
Line 1:

Line 2:

City: State: Zip: –

Start Date: | End Date:

7. LICENSE INFORMATION (If appointment requested, please indicate the line requested.)

Resident License State	Resident License Number	Res. License Line of Business	Appt. Req. / Line of Business

Non-Res. Lic. State	Non-Res. Lic. County	Non-Res. License Number	Non-Res. Lic. Line of Business	Appt. Req. / Line of Business

For a non-resident appointment in Florida, please indicate counties in which you want to be appointed.
A non-resident form is required in HI.

8. NASD LICENSE INFORMATION

Are you NASD licensed / registered ? ☐ Yes ☐ No ☐ Series 6 ☐ Series 7 ☐ Series 63 ☐ Other: _____

Broker / Dealer Affiliation	Individual CRD #

9. E & O POLICY INFORMATION

Policy Amount	Policy Number	Policy Carrier	Effective Date	Expiration Date

10. BUSINESS PRACTICES

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

	Y / N
1. Have you ever had an insurance license or appointment, or a securities registration, or an application for such, denied, suspended, cancelled or revoked?	☐
2. Has any legal or regulatory body ever sanctioned, censured, penalized or otherwise disciplined you?	☐
3. Has any state or federal regulatory agency or self-regulatory authority ever filed a complaint against you?	☐
4. Have you ever been subject to an insurance or investment related consumer initiated complaint or proceeding?	☐
5. Has a bonding or surety company denied, ever paid out on, or revoked a bond for you?	☐
6. Has an E & O carrier ever denied claims, paid claims, or cancelled your coverage?	☐
7. Have you individually, or has a company you exercised control over, filed a bankruptcy petition or been the subject of an involuntary bankruptcy petition?	☐
8. Are there are any unsatisfied judgements, garnishments or liens against you?	☐
9. Are you in debt to any insurance company?	☐
10. Have ever been indicted for, convicted of or pled guilty or nolo contendre to any felony or misdemeanor other than a minor traffic offense?	☐
11. Are you currently party to any litigation or the subject of any investigations?	☐

11. TAXPAYER IDENTIFICATION NUMBER CERTIFICATION

Under penalties of perjury, I certify that:

1. **The number 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 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. person (including a U.S. resident alien).**

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.

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

Name (Please Print)

Signature	Date (mm/dd/yyyy)

12. AUTHORIZATION

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

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

I acknowledge and agree that this Producer Appointment Data Sheet does not constitute a contract of any kind. I hereby authorize the Company and its authorized agents to investigate my background, references, character, past employment, education, criminal or police reports, including those mandated by both public and private organizations and all public records for the purpose of confirming the information contained on this application and/or obtaining other information which may be material to my qualifications for my appointment. I hereby consent to the Company obtaining such information from time to time, as the Company, in its sole discretion, deems necessary. I further consent to the disclosure of the Producer Appointment Form and background information to government or regulatory agencies.

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

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

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

For Maine Applicants Only

Upon request, you will be informed whether or not an investigative consumer report was requested, and if such a report was requested, the name and address of the consumer reporting agency furnishing the report. You may request and receive from us, within 5 business days of our receipt of your request, the name, address and telephone number of the nearest unit designated to handle inquiries for the consumer reporting agency issuing an investigative consumer report concerning you. You also have the right, under Maine law, to request and promptly receive from all such agencies copies of any reports.

For New York Applicants Only

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

For Washington Applicants Only

If we request an investigative consumer report, you have the right, upon written request made within a reasonable period of time, to receive from us a complete and accurate disclosure of the nature and scope of the investigation. You have the right to request from the consumer reporting agency a summary of your rights and remedies under state law.

For California*, Minnesota, and Oklahoma Applicants Only

A consumer credit report will be obtained through:

Business Information Group	PO Box 541	
Company Name	**Street Address**	
Southampton	PA	18966
City	**State**	**Zip Code**

If a **consumer credit report** is obtained, I understand that I am entitled to receive a copy. I have indicated below whether I would like a copy.

YES _____ **Initials** **NO** _____ **Initials**

If an **investigative consumer report** and/or consumer report is processed, I understand that I am entitled to receive a copy. I have indicated below whether I would like a copy.

YES _____ **Initials** **NO** _____ **Initials**

*** California Applicants**: If you chose to receive a copy of the consumer report, it will be sent within three (3) days of the employer receiving a copy of the consumer report and you will receive a copy of the investigative consumer report within seven (7) days of the employer's receipt of the report (unless you elected not to get a copy of the report).

Name (Please Print)

Signature	Date (mm/dd/yyyy)

13. REMARKS

APPOINTMENT INFORMATION

INSTRUCTIONS TO BECOME APPOINTED & CONTRACTED WITH COMPANION LIFE:

1. Attach a photocopy of your current Producer license.
2. If Commissions are being paid to the agency, please attach a photocopy of Agency License.
3. All information **must be** filled in and this form signed and dated before it can be processed.
4. **Please submit these documents with your first Group Case. Thank you.**

NAME _____ NICKNAME _____

BUSINESS NAME _____

BUSINESS OVERNIGHT
MAILING ADDRESS _____
(STREET) (CITY) (STATE) (ZIP)

E-MAIL ADDRESS _____

BUSINESS PHONE (___) _____ FAX NUMBER (_____) _____

HOME ADDRESS _____
(STREET) (CITY) (STATE) (ZIP)

COUNTY _____

SEND CORRESPONDENCE TO: _____ BUSINESS OR _____ HOME

HOME PHONE (___) _____

SOCIAL SECURITY NUMBER _____ DATE OF BIRTH _____

IF COMMISSIONS ARE TO BE PAID TO YOUR AGENCY GIVE NAME AND TAX ID AHCP 02-0690863

Yes	No	
θ	θ	Have you ever been convicted of any felony involving dishonesty or breach of trust?
θ	θ	Have you ever been convicted of a crime involving moral turpitude since becoming licensed?
θ	θ	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.?
θ	θ	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)?
θ	θ	Do you have an outstanding debt with any insurance company?
θ	θ	Have you ever been bankrupt or insolvent, either personally or professionally?
θ	θ	Has an insurance company ever canceled a contract with you?
θ	θ	Have you ever had a complaint filed against you by a state or provincial insurance department?
θ	θ	Have you ever had an insurance license denied or revoked by a state or province?
θ	θ	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.

All appointed agents must comply with all insurance laws, regulations and insurance department bulletins in the jurisdictions in which he is appointed. The applicant may not use, distribute, or publish any advertisement (as defined by the laws of the jurisdiction for which the applicant is appointed), solicitation material, or proposal which has not been filed with and approved in writing by Companion Life Insurance Company. The applicant shall not use Companion service or trade marks without prior written approval from Companion Life Insurance Company. The applicant agrees to assist and cooperate with Companion Life Insurance Company regarding any and all insurance department inquiries, complaints, or investigations.

I certify that all statements are true and correct to the best of my knowledge.

I understand that in compliance with Public law 91-508 (Fair Credit Reporting Act), an investigative consumer report may be prepared from information obtained from person with whom I am acquainted. Inquiry may include information as to my character, general reputation, personal characteristics and mode of living.

I understand that I have the right to make a written request, within a reasonable period of time, to receive information about the nature and scope of this investigation.

_____ _____
DATE SIGNATURE

Rev June 06

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 incorporates 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. **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.

5. **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. Business Associate will indemnify and hold harmless Company and any Company affiliate, officer, director, employee or agent from and against any claim, cause of action, liability, damage, cost or expense, including attorneys' fees and court or proceeding costs, arising out of or in connection with any non-permitted or violating use or disclosure of PHI and electronic PHI or other breach of this Agreement by Business Associate or any subcontractor, agent, person or entity under Business Associate's control.

a) Right to Tender or Undertake Defense. If Company is named a party in any judicial, administrative or other proceeding arising out of or in connection with any non-permitted or violating use or disclosure of PHI and electronic PHI or other breach of this Agreement by Business Associate or any subcontractor, agent, person or entity under Business Associate's control, Company will have the option at any time to either: (i) tender its defense to Business Associate, in which case Business Associate will provide qualified attorneys, consultants, and other appropriate professionals to represent Company's interests at Business Associate's expense, or (ii) undertake its own defense, choosing the attorneys, consultants, and other appropriate professionals to represent its interests, in which case Business Associate will be responsible for and pay the reasonable fees and expenses of such attorneys, consultants, and other professionals.

b) Right to Control Resolution. Company will have the sole right and discretion to settle, compromise or otherwise resolve any and all claims, causes of actions, liabilities or damages against it, notwithstanding that Company may have tendered its defense to Business Associate. Any such resolution will not relieve Business Associate of its obligation to indemnify Company under this Agreement Section E.2.

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.

	Companion Life Insurance Company
Print Agency/Agent Name	
By:_____	By:_____
Printed Name:_____	Printed Name: Trescott N. Hinton, Jr.
SSN:_____	Title: President
Title: _____	Date:_____
Date:_____	

Rev (12/11)

P&C PRODUCER APPOINTMENT FORM
APPOINTMENT SECTION

DATE (MM/DD/YYYY)

PROVIDE ALL INFORMATION KNOWN AT THE TIME THE FORM IS COMPLETED

CARRIER	NAIC CODE
Starr Indemnity & Liability Company	38318

AGENCY INFORMATION

NAME AND ADDRESS	FEIN:
	LICENSING CONTACT: AHCP Agent Services
	CONTACT PHONE (A/C, No, Ext): 877-228-8773
	CONTACT FAX (A/C, No): 888-781-0586
	CONTACT E-MAIL: contracting@ahcpsales.com

PRODUCER INFORMATION

FULL LEGAL NAME	PREFIX	FIRST NAME	MIDDLE NAME	SURNAME	SUFFIX

POSITION / TITLE IN AGENCY	BIRTH DATE (MM/DD/YYYY)	NATIONAL PRODUCER #	SOCIAL SECURITY #

RESIDENCE ADDRESS (Including County)	BUSINESS PHONE (AC, No, Ext):
	BUSINESS E-MAIL ADDRESS

OTHER NAMES USED

PREFIX	FIRST NAME	MIDDLE NAME	SURNAME	SUFFIX	NAME TYPE (Check One) ALIAS	MAIDEN	PREVIOUS
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐

STATES AND US TERRITORIES (Check all that apply)

☐ ALL STATES

☐ AK ALASKA	☐ KY KENTUCKY	☐ NY NEW YORK
☐ AL ALABAMA	☐ LA LOUISIANA	☐ OH OHIO
☐ AR ARKANSAS	☐ MA MASSACHUSETTS	☐ OK OKLAHOMA
☐ AZ ARIZONA	☐ MD MARYLAND	☐ OR OREGON
☐ CA CALIFORNIA	☐ ME MAINE	☐ PA PENNSYLVANIA
☐ CO COLORADO	☐ MI MICHIGAN	☐ RI RHODE ISLAND
☐ CT CONNECTICUT	☐ MN MINNESOTA	☐ SC SOUTH CAROLINA
☐ DC DISTRICT OF COLUMBIA	☐ MO MISSOURI	☐ SD SOUTH DAKOTA
☐ DE DELAWARE	☐ MS MISSISSIPPI	☐ TN TENNESSEE
☐ FL FLORIDA	☐ MT MONTANA	☐ TX TEXAS
☐ GA GEORGIA	☐ NC NORTH CAROLINA	☐ UT UTAH
☐ HI HAWAII	☐ ND NORTH DAKOTA	☐ VA VIRGINIA
☐ IA IOWA	☐ NE NEBRASKA	☐ VT VERMONT
☐ ID IDAHO	☐ NH NEW HAMPSHIRE	☐ WA WASHINGTON
☐ IL ILLINOIS	☐ NJ NEW JERSEY	☐ WI WISCONSIN
☐ IN INDIANA	☐ NM NEW MEXICO	☐ WV WEST VIRGINIA
☐ KS KANSAS	☐ NV NEVADA	☐ WY WYOMING

☐ ALL TERRITORIES

- ☐ AS AMERICAN SAMOA
- ☐ GU GUAM
- ☐ PR PUERTO RICO
- ☐ VI VIRGIN ISLANDS

P&C PRODUCER APPOINTMENT FORM
BACKGROUND QUESTIONS

DATE (MM/DD/YYYY)

PROVIDE ALL INFORMATION KNOWN AT THE TIME THE FORM IS COMPLETED

COMPLETE ONLY FOR THOSE INSURERS REQUIRING THIS INFORMATION

CARRIER	NAIC CODE
Starr Indemnity & Liability Company	38318

BACKGROUND QUESTIONS

EXPLAIN ALL "YES" RESPONSES. PROVIDE COMPLETE DETAILS AND ATTACH APPROPRIATE DOCUMENTS (e.g., Official Court Records).	Y/N
1. HAVE YOU FILED FOR, OR BEEN DISCHARGED FROM ANY BANKRUPTCY (INCLUDING PERSONAL BANKRUPTCY), INSOLVENCY OR ASSIGNMENT FOR THE BENEFIT OF CREDITORS WITH A FILING OR DISCHARGE DATE, WHICHEVER IS LATER, IN THE LAST FIVE (5) YEARS?	☐
2. DO YOU HAVE DELINQUENT UNPAID DEBTS EXCEEDING, IN TOTAL, $10,000? (ADD TOGETHER DELINQUENT: CONSUMER DEBT, TAX LIENS, LOANS, CHILD SUPPORT PAYMENTS, ALIMONY PAYMENTS, CIVIL JUDGMENTS, AND OTHER DELINQUENT DEBT.)	☐
3. WITH THE EXCEPTION OF SITUATIONS SPECIFIC TO CONTINUING EDUCATION, HAVE YOU EVER BEEN THE SUBJECT OF AN ADMINISTRATIVE PROCEEDING REGARDING ANY PROFESSIONAL OR OCCUPATIONAL LICENSE THAT RESULTED IN DISCIPLINARY ACTION?	☐
4. WITH THE EXCEPTION OF SITUATIONS SPECIFIC TO CONTINUING EDUCATION, HAS YOUR INSURANCE LICENSE EVER BEEN SUSPENDED BY, SUBJECT TO A CONSENT ORDER FROM, REVOKED BY, OR SURRENDERED TO, ANY REGULATORY AGENCY, OR HAVE YOU EVER BEEN FINED, PENALIZED, SANCTIONED OR SUBJECT TO ANY OTHER DISCIPLINARY ACTION BY A STATE OR FEDERAL REGULATORY AGENCY OR SELF REGULATORY ORGANIZATION OR ARE YOU CURRENTLY UNDER INVESTIGATION AS A RESULT OF YOUR ACTIVITIES IN THE BUSINESS OF INSURANCE, SECURITIES, BANKING, INVESTMENT BANKING OR REAL ESTATE?	☐
5. HAVE YOU EVER HAD AN INSURANCE AGENCY CONTRACT OR ANY OTHER BUSINESS RELATIONSHIP WITH AN INSURANCE COMPANY TERMINATED FOR ANY ALLEGED MISCONDUCT?	☐
6. HAVE YOU EVER BEEN CONVICTED OF, PLEAD GUILTY OR NO CONTEST TO, OR ARE YOU CURRENTLY CHARGED WITH OR UNDER INVESTIGATION FOR ANY MISDEMEANOR INVOLVING DISHONESTY OR BREACH OF TRUST OR ANY FELONY?	☐
7. ARE YOU NOW THE SUBJECT OF ANY COMPLAINT, INVESTIGATION, OR PROCEEDING THAT COULD RESULT IN A "YES" ANSWER TO ANY OF THE PREVIOUS QUESTIONS?	☐

REMARKS

I HEREBY CERTIFY THAT ALL OF THE INFORMATION HEREIN IS ACCURATE AND COMPLETE. I ACKNOWLEDGE AND AGREE THAT MY APPOINTMENT WILL, IN PART, BE BASED ON THIS PRODUCER APPOINTMENT FORM AND BACKGROUND INFORMATION, AND ANY FALSIFICATION, MISREPRESENTATION OR OMISSION OF INFORMATION FROM THIS FORM MAY RESULT IN THE WITHHOLDING OR WITHDRAWAL OF ANY OFFER OF APPOINTMENT OR THE REVOCATION OF APPOINTMENT BY THE COMPANY WHENEVER DISCOVERED.

PRINT NAME	
SIGNATURE	DATE (MM/DD/YYYY)

ATTACH TO ACORD 817

NOTICE OF BACKGROUND CHECK AND FAIR CREDIT REPORTING ACT DISCLOSURE

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

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

I acknowledge and agree that this Producer Appointment Form does not constitute a contract of any kind. I hereby authorize the Company and its authorized agents to investigate my background, references, character, past employment, education, criminal or police reports, including those mandated by both public and private organizations and all public records for the purpose of confirming the information contained on this application and/or obtaining other information which may be material to my qualifications for my appointment. I hereby consent to the Company obtaining such information from time to time, as the Company, in its sole discretion, deems necessary. I further consent to the disclosure of the Producer Appointment Form and background information to government or regulatory agencies.

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

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

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

For Maine Applicants Only

Upon request, you will be informed whether or not an investigative consumer report was requested, and if such a report was requested, the name and address of the consumer reporting agency furnishing the report. You may request and receive from us, within 5 business days of our receipt of your request, the name, address and telephone number of the nearest unit designated to handle inquiries for the consumer reporting agency issuing an investigative consumer report concerning you. You also have the right, under Maine law, to request and promptly receive from all such agencies copies of any reports.

For New York Applicants Only

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

For Washington Applicants Only

If we request an investigative consumer report, you have the right, upon written request made within a reasonable period of time, to receive from us a complete and accurate disclosure of the nature and scope of the investigation. You have the right to request from the consumer reporting agency a summary of your rights and remedies under state law.

For California*, Minnesota, and Oklahoma Applicants Only

A consumer credit report will be obtained through:

Company Name	Street Address	
Business Information Group	PO Box 541	
City	**State**	**Zip Code**
Southampton	PA	18966

If a **consumer credit report** is obtained, I understand that I am entitled to receive a copy. I have indicated below whether I would like a copy.

YES _____ Initials NO _____ Initials

If an **investigative consumer report** and/or consumer report is processed, I understand that I am entitled to receive a copy. I have indicated below whether I would like a copy.

YES _____ Initials NO _____ Initials

*** California Applicants**: If you chose to receive a copy of the consumer report, it will be sent within three (3) days of the employer receiving a copy of the consumer report and you will receive a copy of the investigative consumer report within seven (7) days of the employer's receipt of the report (unless you elected not to get a copy of the report).

PRINT NAME	
SIGNATURE	DATE (MM/DD/YYYY)

Authorization for Automatic Deposit

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

Agent or Agency Name	
Social Security Number or Tax ID Number	
Phone Number	Email Address
Please indicate transaction type: [ ] Set-Up [ ] Change [ ] Cancel	
Please indicate type of account: [ ] Checking [ ] Savings	
Name of Financial Institution:	
Bank—City, State, Phone Number:	
Routing Number:	
Account Number:	

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

Agent Signature_____ **Date**_____

PLEASE INCLUDE A COPY OF A VOIDED CHECK

Fax this form to AHCP– 888-781-0586
Scanned versions of this form can be emailed to contracting@AHCPsales.com

Form **W-9**
(Rev. December 2011)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

Print or type
See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

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

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

☐ Other (see instructions) ▶

☐ Exempt payee

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

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

Social security number

			–		–				

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here Signature of U.S. person ▶ Date ▶

General Instructions

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

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

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

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

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

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

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

PRODUCER AGREEMENT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Executed as the _____ day of _____ 20___.

By: _____ _____
Agent's Signature Print Name

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

ADDENDUM A
ASSIGNMENT OF COMMISSIONS AGREEMENT

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

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

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

1. All earned commissions assigned to and received b AHCP are received on the Agent's behalf and will promptly be paid out in its entirety to the Agent pursuant to the commissions structure and advance commission agreement between AHCP and the Agent. All commission payments will be made by AHCP or its delegate.

2. Agent may, upon written notice to AHCP, opt out of receiving any advance commissions. AHCP will pay out to Agent all earned commissions.

3. AHCP reserves the right to modify commission or advance commission agreements to providing 10 days advance written notice to Agent.

4. Agent expressly acknowledges that advance commission from AHCP may result in debit balances being owed by Agent to AHCP. Agent understands that these debit balances are loans which are tied to Agent and must be repaid to AHCP. If AHCP determines that monthly commissions will not satisfy the debit balance within 10 months, AHCP may, upon written notice to Agent, use Agent's commissions from any AHCP Carrier to reduce any debit balances.

5. AHCP may not assign commissions to any unaffiliated party without Agent's express written consent.

6. This assignment only applies to commissions for AHCP business while this agreement is in effect. Subject to use of commission to repay debit balances owed, AHCP shall retain no interest in or control of business sold by Agent. AHCP expressly acknowledges that this agreement in no way changes or affects the Agent's status as "Agent of Record" for any business for which commissions have been assigned to AHCP.
7. This assignment may be revoked by Agent upon 30 days written notice to AHCP and the Carrier. Once revoked, Agent will be entitled to receive commissions from Carriers so long as all debit balances with AHCP have been paid.

8. AHCP does not impose a vesting schedule on Agent. Agent is immediately vested per Carrier's requirements. AHCP will use reasonable efforts to provide vesting information from Carriers to Agent.

_____ _____
Agent Signature Date