

National Insurance Benefit Coordinators, Inc.

Appointment Instructions for
Coventry / First Health RX

Please complete the following:

1. _____ **Contract Information:** Complete and sign.
2. _____ **Additional Address:** Complete if necessary.
3. _____ **Marketing Summary Sheet:** Complete.
4. _____ **W-9:** Complete and sign.
5. _____ **EFT Authorization form:** Complete, sign and include copy of voided check.
6. _____ **State License:** Please provide a copy of your resident state license and any non-resident licenses for the states you wish to be appointed in.
7. _____ **CMS or AHIP:** Please provide a copy of your CMS or AHIP certification.

Once all information has been completed you can fax the attached information to 501-372-2221 or e-mail to karen@nibconline.com .

If you have any questions please call us at 501-372-4800.

National Insurance Benefit Coordinators, Inc.

112 Smart House Way
North Little Rock, AR 72114
(501) 372-4800 phone
(501) 372-2221 fax

CONTRACT INFORMATION SHEET

INSTRUCTIONS: Please complete all information.

Agent Information:

Broker/Agent Name: LAST: _____ FIRST: _____ MI: _____
(Name as it appears on your insurance license)

Agent/Broker SSN: _____ Birth Date: _____ Suffix: _____

Home Telephone Number: _____ Cell Phone Number: _____

Business Phone Number: _____ Ext: _____ Fax Number: _____

E-mail Address: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Commission Statement Addresses:

Yes No Is this address same as your Home Mailing Address?

If yes, skip this section, if no, please complete Commission Statement Address.

Street Address 1: _____

Street Address 2: _____

City: _____ State: _____ Zip Code: _____

License Information:

Resident License #: _____ License State: _____

Non Resident License #: _____ License State: _____

Non Resident License #: _____ License State: _____

Non Resident License #: _____ License State: _____

Appointment State Information:

If more than five appointment states are needed, please complete the optional form titled "Additional Appt States"

Resident Appointment State: _____

Non Resident Appointment State: _____ Non Resident Appointment State: _____

Non Resident Appointment State: _____ Non Resident Appointment State: _____

Background Information:

Please provide answers to the following questions:

Have you ever been fined suspended, placed on probation, paid administrative costs, entered into a consent order, been issued a restricted license or otherwise been disciplined or reprimanded, or are you currently under investigation by any insurance department, the NASD, SEC or any other regulatory authority? YES NO

Have you ever been convicted or plead guilty or nolo contendere (no contest), served any probation, paid any fines or court costs, had charges dismissed through any type of first offender or deferred adjudication or suspended sentence procedure, or are any charges currently pending against you for any offense other than a minor traffic violation? YES NO

If you answered yes to any of the questions above please explain:

Errors & Omissions Information:

Do you currently have errors and omissions insurance? YES NO

Proof of Coverage must be attached/faxed to Coventry. Failure to submit this information will result in rejection of this contract.

Name of Carrier: _____ Policy Number: _____

Per Incident: \$ _____ Per Year: \$ _____

Effective Date: _____ Expiration Date: _____

(Agent must maintain E&O coverage as referenced in your contract)

Certification Information:

I have completed and successfully passed the training.

Commissions **will not be paid** on any sales prior to successful completion of my certification.

Agency Information:

Are you the principal of an agency? Yes No

Agency Name: _____ TIN: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Agency License Number: _____ License State: _____

Authorization:

I am assenting to the terms and conditions of this Selling Agreement.



(

Name Last: First: Middle Init:

Social Security #

Past Address Street: City:
State: Country: Zip Code:
At this address: From: (mm/yyyy) To: (mm/yyyy)

Past Address Street: City:
State: Country: Zip Code:
At this address: From: (mm/yyyy) To: (mm/yyyy)

Past Address Street: City:
State: Country: Zip Code:
At this address: From: (mm/yyyy) To: (mm/yyyy)

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Past Address Street: City:
State: Country: Zip Code:
At this address: From: (mm/yyyy) To: (mm/yyyy)



ACKNOWLEDGEMENT AND AUTHORIZATION FOR CONSUMER REPORTS

Coventry Health Care, Inc.

In connection with your application to become an authorized agent to sell insurance products offered by affiliates of Coventry Health Care, Inc., you understand that consumer reports or investigative consumer reports may be requested about you including information about your character, general reputation, personal characteristics and mode of living, employment record, education, qualifications, criminal record, driving record, credentials, and/or credit and indebtedness, and may involve personal interviews with sources such as supervisors, friends, neighbors, associates, public record or various Federal, State, or Local agencies. A consumer report containing injury and/or medical information may be obtained after a tentative offer of a contract to be an agent for Coventry has been made.

You hereby authorize the obtaining of such consumer reports and investigative consumer reports at any time after execution of this authorization. By signing below, you hereby authorize without reservation, any party or agency contacted by Coventry, or the consumer reporting agency acting on behalf of Coventry, to furnish the above mentioned information. You further authorize ongoing procurement of the above mentioned reports at any time during your continued contractual relationship with Coventry. You also agree that a fax or photocopy of this authorization with your signature shall be accepted with the same authority as the original.

For California, Minnesota or Oklahoma applicants only, if you would like to receive a copy of the consumer report, if one is obtained, please check this box.

For California applicants only, if public record information is obtained without using a consumer reporting agency, you will be supplied a copy of the public record information unless you check this box waiving your right to obtain a copy of the report.

Printed Name: _____

Signature: _____

Date: _____

Social Security #: _____

Current Address: _____

Other Names Used: _____

Include Maiden or Name Changes, No Direct Derivatives Ex: Susan vs. Sue, David vs. Dave, etc.

DL #: _____

State: _____

DOB: _____



Marketing Summary Sheet

Contract Name:			
Address: _____			
Telephone Numbers	Primary:	Mobile:	
What states do you Market in:			
Number of agents:			
E-mail address:			
How Long in Business:	How Long in Senior Market:		
List of Current Carrier Contracts (Continue on a separate Sheet if necessary)			Effective Date of Contract
			Effective Date of Contract
			Effective Date of Contract
2007 Senior Business Volume	\$	Annual Premium (Estimate)	Or Number of New Members YTD
2008 Senior Business Volume	\$	Annual Premium (Estimate)	Or Number of New Members YTD

Signature

Date

Print Name and Title

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, if different from above	
	Check appropriate box: <input type="checkbox"/> Individual/ Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other ▶	
	<input type="checkbox"/> Exempt from backup withholding	
	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 Line 1 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								

OR

Employer identification number								

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

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. 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. 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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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.

U.S. person. 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.

In 3 above, 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.

For federal tax purposes, you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

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.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,



Payee Name: _____

John Doe 123 Main Street Anywhere, US 12121	5555 Date
Pay to the Order of _____	\$ _____ Dollars
<i>County Bank</i>	
For _____	
Bank Routing Number _____	Account Number _____

Preferred Method of Payment: Electronic Funds Transfer Check

_____ (“Payee”) hereby (1) authorizes Coventry Health Care, Inc. and its corporate affiliates (collectively “CHC”) to make payments for Payee’s services by Electronic Fund Transfer (EFT), (2) certifies that the Payee has selected the following depository institution, and (3) directs that all such EFT’s be made as provided below:

Depository Institution: _____

Bank Routing Number: _____ Account Number: _____

Account Type: Checking Savings

Payee’s Tax Id or Social Security Number: _____

Payee will give thirty (30) days advance notice in writing to CHC of any changes in its depository institution or other payment instructions.

When properly executed, this Authorization will become effective within thirty (30) days after its receipt by CHC. CHC also reserves the right to recall an EFT transaction if incorrect.

Before submitting this authorization form, the Payee should check with its banking institution to verify that it will be able to receive Automated Clearing House (ACH) transactions and if there are any associated fees for this service. To ensure the correct banking information is entered into our system, please attach a copy of a voided check for the depositing account.

Authorized Signature

Title

Date