

National Insurance Benefit Coordinators, Inc.

Appointment Instructions for *United HealthCare*

Please complete the following:

1. _____ **Agent Agreement:** Complete all required information and sign.
2. _____ **Appointment Application:** Complete all required information. Answer each question by marking the appropriate box. If you answer yes to any question please provide a detailed explanation.
3. _____ **Assignment of Commissions:** Complete and sign only IF assigning commissions.
4. _____ **W-9 & EFT Form:** Complete and sign and return voided check.
5. _____ **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.
6. _____ **E&O:** United HealthCare *requires* all agents to carry E&O coverage. Please provide a copy of your E&O Certificate.
7. _____ **AHIP:** Please provide a copy of your AHIP certification for appointment.

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

UNITED HEALTHCARE INSURANCE COMPANY AGENT AGREEMENT

This AGENT AGREEMENT (this "Agreement") is made and entered into this ____ day of _____, 20__, by and between United HealthCare Insurance Company, ("United"), on behalf of itself and its Affiliates (collectively, the "Company") and _____ ("Agent").

A. United and certain of its Affiliates offer Medicare Advantage Plans ("MA Plans"), stand-alone prescription drug plans ("PDP Plans"), Medicare supplement insurance plans ("Med Supp Plans") and other health plans and products as may be designated by the Company (collectively, the "Products").

B. FMO or General Agent has recommended Agent for appointment by the Company to market and promote the Products.

NOW, THEREFORE, in consideration of the mutual covenants in this Agreement, it is agreed as follows:

ARTICLE ONE DEFINITIONS

1.1 **Affiliate** is any entity which directly or indirectly, through one or more intermediaries, owns or controls, is controlled or owned by or is under common ownership or control with United, and offers one or more of the Products. Affiliates offering the Products shall be specified in the Agent Compensation Schedule attached hereto and incorporated herein as **Exhibit A** to this Agreement.

1.2 **CMS** is the Centers for Medicare & Medicaid Services.

1.3 **CMS Contract** is the contract entered into by CMS and the Company pursuant to which the Company offers the MA Plans and PDP Plans in a specified service area or region.

1.4 **Field Marketing Organization (FMO)** is an independent contractor, who or which has entered into a contract with Company for the marketing and promotion of the Products and has directly or indirectly through a General Agent recommended Agent for appointment by the Company to market and promote the Products.

1.5 **General Agent** is an appropriately licensed, independent contractor, appointed by the Company, free to exercise his or its own judgment as to the time and manner of performing services pursuant to an agreement between the General Agent and the Company and authorized to recommend another agent for appointment as a General Agent, Agent or Solicitor Agent. A General Agent can be categorized in any one of three levels, General Agent (GA), Super General Agent (SGA) or Master General Agent (MGA) as set forth in the Relationship Hierarchy attached hereto and incorporated herein as **Exhibit B**. For clarification, an SGA can recommend an MGA, GA, Agent and Solicitor Agent; and an MGA can recommend a GA, Agent, and Solicitor Agent.

1.6 **MA Plan** is any Medicare Advantage Plan that may now or in the future be offered to individual Medicare beneficiaries by the Company and subject to this Agreement, including, but not limited to, Local HMO and PPO Plans ("Local MA Plans"), Special Needs Plans ("SNPs"), Regional Preferred Provider Plans, and Private Fee for Service Plans ("PFFS Plans"). The definition of MA Plan includes MA Plans which include prescription drug plan benefits ("MA-PD Plans").

1.7 **Med Supp Plan** is a Medicare supplement insurance product authorized under applicable federal and state laws and regulations that may now or in the future be offered to individual beneficiaries by the Company.

The following exhibits and attachments are incorporated by reference into this Agreement:

- ___ **Exhibit A** Agent Compensation Schedule
- ___ **Exhibit B** Hierarchy Relationship Addendum
- ___ **Exhibit C** Medicare Regulatory Addendum
- ___ **Exhibit D** HIPAA Business Associate Addendum
- ___ **Exhibit E** Branded Products Addendum

Executed this ____ day of _____, 20__.

AGENT CONTRACTING AS

**UNITED HEALTHCARE INSURANCE
COMPANY, on behalf of itself and its Affiliates**

(Check one)

- INDIVIDUAL**
- PARTNERSHIP**
- CORPORATION**

Print Name on License

By: _____
Authorized Signature

By: _____
Company Officer

Title: _____

Title: _____

Address

City State Zip Code

Telephone Number: _____

Fax Number: _____

E-mail: _____

Tax I.D. Number: _____



Appointment Application

Field Marketing Organization (FMO) Channel

United Healthcare Insurance Company and Affiliates

Please Print or Type: All fields must be complete and legible.

Type of Request: NEW _____ CHANGE _____

Individual Information (All Individual Information Fields Required for All Appointment Applications)			
Legal Name (As it appears on your Individual Resident State Insurance License)		Alias/Other Names	
Social Security #		Date of Birth	
Home Address			
City	State	County	Zip
Home Phone	Business Phone	Fax	
E-mail Address (required)			

Appointment Type: <input type="checkbox"/> Individual OR <input type="checkbox"/> Corporation <i>This must match information provided on Agreement and the W-9.</i>	Mailing Preference: <input type="checkbox"/> Home OR <input type="checkbox"/> Business <i>If applying as an Individual, but prefer mail be delivered to your business, fill in the Business Address section below.</i>
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If applying as a Corporation, the following information is also Required (Please note that you must be a Principal of the Corporation to apply as such)

Corporation Name	Principal		
Corporate Tax ID	Business Phone		
Business Address			
City	State	County	Zip

Please list the states for which you are applying for appointment:	*Must include resident state *Must be licensed in each state listed	*All states subject to individual review *Listing a state does not guarantee appointment for that state
Resident State:	Non-Resident States:	

Errors and Omissions Coverage

AN ACTIVE POLICY DECLARATION PAGE WITH YOUR NAME LISTED AS THE COVERED ENTITY MUST BE ATTACHED

Name of Carrier _____

Policy # _____ Expiration Date _____
 (\$1,000,000 per occurrence and \$1,000,000 annual aggregate required)



Appointment Application

Field Marketing Organization – FMO Channel

United Healthcare Insurance Company and Affiliates

Note: Failure to accurately and honestly answer any of the following questions may result in a declination of your application and appointment with UnitedHealthcare.

If you answer “yes” to any of these questions, please provide supporting documentation and a brief explanation on a separate sheet of paper.

Criminal Background Information:

1. Yes No Have you ever been convicted of a felony?
2. Yes No Have you ever been convicted of a misdemeanor (other than traffic) including an alcohol or drug related offense?
3. Yes No Have you had your driver’s license revoked within the past three years?

Departments of Insurance and CMS:

4. Yes No Have you ever had your insurance or securities license revoked and/or suspended by any department of insurance (even if later reinstated) for any reason?
5. Yes No Have you ever had a complaint reported against you (even if dismissed) by a consumer and/or insurance company for any reason with any department of insurance, NASD, or other regulatory reporting agency including CMS?
6. Yes No Have you ever paid a fine related to a consumer complaint, failure to renew your license or continuing education credit in excess of \$500?
7. Yes No Have you ever been excluded, or are you aware of actions that could result in an exclusion, by the Office of Inspector General from participation in a government health care program, including Medicare or Medicaid?

Credit History:

8. Yes No Have you filed for bankruptcy and/or had a bankruptcy discharged within the last five years?
9. Yes No Are you, at the present time, or have you ever been within the past five years, involved in any civil litigation, judgments, liens or foreclosures?
10. Yes No Are you, at the present time, or have you ever been within the past five years, reported as delinquent on state or federal taxes?

Other Companies:

11. Yes No Do you owe any insurance company, marketing organization or individual for any premiums collected or monies advanced?
12. Yes No Have you been denied an appointment with any insurance company?
13. Yes No Have you been denied a bond or application for errors and omissions (E&O) coverage with any company?

Other:

1. Yes No Do you have other information related to criminal, insurance related complaints, credit, etc. that was not covered by these questions that you wish to disclose?



Appointment Application Field Marketing Organization – FMO Channel

United Healthcare Insurance Company and Affiliates

Conditions and Agreements

I have thoroughly reviewed this application and have answered all questions to the best of my knowledge. By signing below, I hereby attest to all matters set forth above and agree to all matters set forth below. I hereby agree that if and when any or all of the companies issue to me any Agreement(s) for which I hereby apply, I will be bound by such Agreement(s). I understand that my supervising office has specimen forms of the Agreement(s) on file and I have had the opportunity to review such Agreement(s). Submitting to the Company any application for insurance products, including but not limited to Medicare Advantage and Prescription Drug Plan shall constitute my agreement to such Agreement(s) and all the terms, conditions and provisions set forth therein. I acknowledge that by signing this Appointment Application and submitting any such insurance application for Insured Product, I have so agreed to the Agreement(s) and no future signature by me shall be necessary.

Disclosure

I have executed this Appointment Application as evidence of the understanding and acceptance of, and consent to its terms, and I agree that I will not solicit business until I receive notification from the Company that this acknowledgement has been approved and I have satisfied all of the certification requirements for the products I intend to sell. I understand that as part of its approval process, the Company may obtain an investigative consumer report which will confirm information regarding my character, general reputation, credit history, personal characteristics and mode of living. I hereby authorize the Company to obtain such a report.

Applicant Signature _____ Date _____

Please return all documents to your Field Marketing Organization (FMO) Recruiter for submission to UnitedHealthcare.



United Healthcare Insurance Company
Assignment of Commissions

To _____ Tax ID _____
(Herein called the Assignee)

Assignee's Address _____

City _____ State _____ Zip Code _____

Telephone _____

For valuable consideration, the undersigned, herein called the Assignor, hereby assigns to the Assignee all of the Assignor's right, title, interest, claim or demand in and to any and all compensation now due and payable, or which may become due and payable, under existing contracts and agreements heretofore entered into by and between United Healthcare Insurance Company, on behalf of itself and its affiliates (collectively, the "Company") and Assignor.

Assignor hereby authorizes and empowers the Company to pay Assignee all compensation (including but not limited to over-riding commissions) now due or which may become due under the Agreement until such time as Assignor terminates this assignment by written notice to the Company. Assignor acknowledges and agrees that such payment of compensation to Assignee shall constitute payment of such compensation to the Assignor as if paid directly to the Assignor and the Company shall be fully released from any and all responsibility to the Assignor for such payments. Assignor hereby acknowledges and agrees that assignment of compensation payable under the agreement does not release or otherwise relieve

Assignor of any obligation or responsibility under the Agreement including, but not limited to, the obligation to pay commissions to Solicitor Agents and/or the obligation to reimburse the Company for compensation paid on premiums subsequently refunded.

Assignor hereby covenants and agrees that Assignor is the absolute and sole owner of said compensation, free from assignment or encumbrance of any kind or character whatsoever, and has full right and lawful authority to so assign same. The Assignor shall at all times defend, indemnify and hold harmless the Company and its officers, agents, and employees form and against any and all suits, actions, losses, damages, claims, expenses (including but not limited to the Company's legal expenses) and liability of any character, type of description arising out of the execution or performance of this assignment.

Assignor Signature _____ Dated _____

Assignor Name _____
(Print)

Assignee Signature _____ Dated _____

The Company acknowledges receipt of, and consents to the foregoing assignment, but assumes no responsibility for the validity or sufficiency hereof. This assignment is effective on the date signed by an authorized officer of the company.

By _____ Dated _____
(Authorized Company Signature)

Company Officer Name _____ Title _____
(Print)

Request for Taxpayer Identification Number and Certification

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

Please print or type

Name (See **Specific Instructions** on page 2.)

Business name, if different from above. (See **Specific Instructions** on page 2.)

Check appropriate box: Individual/Sole proprietor Corporation Partnership Other ▶

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

Requester's name and address (optional)

City, state, and ZIP code

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. 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 2.** 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 2.

Note: If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.

Social security number								
				+				

or

Employer identification number								
				+				

List account number(s) here (optional)

Part II For U.S. Payees Exempt From Backup Withholding (See the instructions on page 2.)

Part III Certification

Under penalties of perjury, I certify that:

- 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**
- 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**
- 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 2.)

Sign Here

Signature of U.S. person ▶

Date ▶

Purpose of Form

A person who is required to file an information return with the IRS must get 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 give your correct TIN to the person requesting it (the requester) and, when applicable, to:

- Certify the TIN you are giving is correct (or you are waiting for a number to be issued),
- Certify you are not subject to backup withholding, or
- Claim exemption from backup withholding if you are a U.S. exempt payee.

If you are a foreign person, use the appropriate Form W-8. See **Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Corporations.**

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.

What is backup withholding? Persons making certain payments to you must withhold and pay to the IRS 31% of such payments under certain conditions. This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

If you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return, payments you receive will not be subject to backup withholding. **Payments you receive will be subject to backup withholding if:**

- You do not furnish your TIN to the requester, or
- You do not certify your TIN when required (see the Part III instructions on page 2 for details), or
- The IRS tells the requester that you furnished an incorrect TIN, or
- The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the Part II instructions and the separate **Instructions for the Requester of Form W-9.**

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.



Electronic Fund Transfer

SecureHorizons will deposit your check directly to your bank account. We make the deposit according to the current Commission Deposit Schedule. Below is an authorization form so that you may sign up for this service. Just complete the form and mail it back with your appointment paperwork.

Fund Transfer Authorization

I (We) do hereby authorize the deposit of all commission payments due me (us) to my (our) checking account indicated below and the Depository Financial Institution named below to credit the payment (s) to such account by SecureHorizons.

Account Number: _____

Financial Institution Name: _____

City: _____ State: _____

I (We) reserve the right to revoke and cancel this authorization, such revocation and cancellation to take effect upon written notice received at the office of SecureHorizons with reasonable time to act on such notice.

Date Agent Number Agent Signature

ATTACH VOIDED CHECK HERE
(DEPOSIT SLIPS ARE NOT ACCEPTABLE)