# *Agent Contracting Checklist*

## To expedite the contracting process, please follow the steps below:

**Step 1: Complete and Sign the Following Items**

1. **Appointment Application**
2. **Agent Agreement**
3. **State Insurance License-photocopy**
    a. Resident State License – photocopy
    b. Non-Resident License(s) – photocopy for any additional state(s) in which you wish to be appointed
4. **EFT Form (optional)**
    a. Include voided check made payable to Secure Horizons (not deposit slip), if requesting commission direct deposit.
5. **Proof of Errors & Omissions Coverage**
    a. Limits of Liability Required:
    Each Claim Each Insured - $1,000,000
    Aggregate Each Insured - $1,000,000
6. **W-9 Form**
7. **Assignment of Commissions** (If assigning commissions to a Corporation)

**Step 2: Return completed contracting material to us via email or fax:**

**Email:** contracting@garityadvantage.com
**Fax:** 339-469-8155

# 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; and an MGA can recommend a GA, Agent, and Solicitor.

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**

(Check one)
**INDIVIDUAL**
**PARTNERSHIP**
**CORPORATION**

_____
Print Name on License

By: _____
Authorized Signature

Title: _____

_____
Address

_____ ____ _____
City State Zip Code

Telephone Number: _____

Fax Number: _____

E-mail: _____

Tax I.D. Number: _____

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

By: _____
Company Officer

Title: _____

# Appointment Application

UnitedHealthcare Insurance Company and Affiliates

UnitedHealthcare Medicare Solutions

**THIS IS A WRITABLE FORM***

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

| **Individual Information (All Individual Information fields required for all Appointment Applications).** | | | |
|---|---|---|---|
| Legal Name (As name appears on Individual Resident State in insurance License)<br>Last: Middle: First: | | | |
| Social Security Number | Birth Date (MM/DD/YYYY) | Alias/Other Names | |
| Resident Address | | | |
| City | State | County (FL only) | Zip |
| Resident Phone Number | Business Phone Number | Fax Number | |
| Email Address | | | |
| Appointment Type: ☐ Individual OR ☐ Corporation | This must match information provided on the Agreement and W-9. | | |
| Mailing Preference: ☐ Residential OR ☐ Business | If applying as an individual, but prefer mail be delivered to your business, fill in the Business Address section below. | | |

| **If Applying as a Corporation, the following information is also required. (You must be a Principal of the Corporation to Apply).** | | | |
|---|---|---|---|
| Corporation Name | Principal | | |
| Corporate Tax ID | Business Phone | | |
| Business Address | | | |
| City | State | County | Zip |

| **Errors and Omissions Coverage ($1,000,000 per occurrence or $1,000,000 annual aggregate required.)** | | |
|---|---|---|
| **AN ACTIVE POLICY DECLARATION PAGE WITH YOUR NAME LISTED AS THE COVERED ENTITY MUST BE ATTACHED.** | | |
| Name of Carrier | Expiration Date | Policy # |

**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 the next page of this form.**

## Criminal Background Information

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

## Department of Insurance and CMS

4. 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? ☐ Yes ☐ No
5. 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, FINRA, or other regulatory reporting agency including CMS? ☐ Yes ☐ No
6. Have you ever paid a fine related to a consumer complaint, failure to renew your license or continuing education credit in excess of $500? ☐ Yes ☐ No
7. 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 and Medicaid? ☐ Yes ☐ No

## Credit History

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

## Other Companies

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

## Other

15. 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? ☐ Yes ☐ No

**Please provide an explanation for any "Yes" answers on the previous page in the corresponding sections below.**

## Criminal Background Information

## Department of Insurance and CMS

## Credit History

## Other Companies

## Other

## 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 for 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 acknowledgment 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 and throughout the term of my appointment with the Company, the Company may obtain an investigative consumer report to confirm information regarding my character, general reputation, credit history, personal characteristics, mode of living, criminal history, insurance licensing history, Office of Inspector General records and General Service Administrator excluded party records. I hereby authorize the Company to obtain such a report at any time after receipt of this Appointment Application and throughout the term of my appointment with the Company. The scope of this authorization is all-encompassing, allowing the Company to obtain from any outside organization all manner of investigative consumer reports now and throughout my appointment to the extent permitted by law.

| Applicant's Signature | Date | SIGNATURE |
|---|---|---|
| | | |

**Please return all documents to your Recruiter for submission to UnitedHealthcare.**

UnitedHealthcare®
MEDICARE & RETIREMENT

Please check one:
○ New Setup All lines must be completed
○ Terminate Form must be signed by Assignee & Assignor
Fax Completed form to 866-761-9162

# United Healthcare Insurance Company
# Assignment of Commissions

To _____ Tax ID_____
(Herein called the Assignee)

Assignee's Address_____

City_____ State_____ Zip Code_____

Telephone _____ Assignee's Writing ID_____

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 from 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 our of the execution or performance of this assignment.

Assignor Signature _____ Dated _____

Assignor Name _____ Writing ID_____
(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)

**Assignment will not be accepted unless all open fields are completed

# Electronic Funds Transfer

UnitedHealthcare®
Medicare Solutions

To have your commission payments transferred electronically to your checking account or to change the checking account your funds are transferred to, complete the fund transfer authorization below. You will also need to attach a voided check from the checking account you wish to have your commission payments deposited in. Please do not send a deposit slip or cancelled check. Please return the completed authorization via email to sh_commissions_administration@uhc.com or fax it to 1-866-761-9162.

## Fund Transfer Authorization

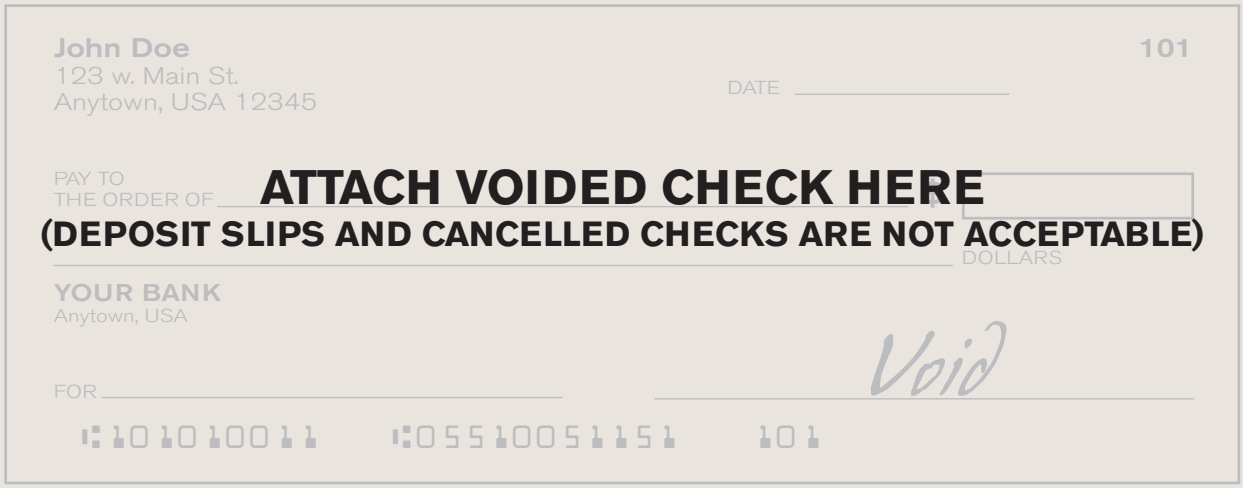
Please indicate: New ____ Change ____

I (We) do hereby authorize UnitedHealthcare® to deposit all commission payments due me to the checking account indicated below and the Depository Financial Institution named below.

| Account Number | |
|---|---|
| Financial Institution Name | |
| City | State |

Please remember to notify us if the bank you use changes its name or merges with another bank or if you change banks and/or if you change bank accounts.

| Agent Signature | | |
|---|---|---|
| Agent Printed Name | Agent Writing ID | Date |



## Cancellation

I revoke and cancel my Funds Transfer Authorization, such revocation and cancellation to take effect upon receipt of this signed cancellation notification at the office of UnitedHealthcare with reasonable time to act on such notice. By cancelling the electronic funds transfer deposit of my compensation payments; I understand that these payments will now be submitted as a paper check.

Please sign, date, and provide your agent number below and return this form to sh_commissions_administration@uhc.com or fax it to 1-866-761-9162.

| Agent Signature | | |
|---|---|---|
| Agent Printed Name | Agent Writing ID | Date |

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) ▶

☐ Exempt payee

☐ Other (see instructions) ▶

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.