

Broker Appointment Process Checklist

Thank you for your interest in marketing Golden Rule's competitive portfolio of health and life insurance products. After your appointment is processed, we will send you a complete marketing package with supplies, rate disks, and broker guides to help you write your first application.

To begin the process, please complete and sign the following:

1) Complete...

- Prospective Broker Application (PBA)**. The application to become appointed and/or authorized to submit applications to us.
- IRS W-9 Form**. Only complete if commissions are paid to you. (If commissions are to be paid to an Agency, complete W-9 with Agency information.)
- Electronic Deposit of Commissions Form**. Only complete if commissions are paid to you. In the interests of security and convenience, we distribute commissions electronically to the financial institution of your choice.
- Independent Broker Contract (IBC) Signature Page**. Read the contract carefully and **complete the Signature Page**. This contract is not effective until Golden Rule has countersigned the Signature Page and attached the appropriate commission schedules. **Keep the contract for your records**. We will send you a copy of the countersigned Signature Page upon approval.

2) Enclose...

- Copy of your state Life and Health license(s)**.
- Applicable state appointment fees**. If you do not wish to pay with a credit card, please submit a check payable to Golden Rule. Call us at 1-800-474-4467 to determine the amount of your state fees.
- If Agency, include **Agency License and Agency Fees**.
- PBA Explanation Page** (for "yes" answers to questions).

3) Submit...

- Fax** your completed Forms and State Insurance License to
- Or**
- Mail** your Prospective Broker Forms directly to:

David A. Crotts & Associates, Inc.
 422 Montague Avenue, Suite #7
 Greenwood, SC 29649
 800-803-7873
 864-223-8788
 864-229-7392 (Fax)

Please note that most areas which require signatures are pointed out with markers such as these:



A UnitedHealthcare Company

GRIC Manager/Representative _____

Independent Broker Financial Services Company Name: _____

Complete Name _____ I prefer to be called: _____

Name of Agency or Company _____

Business Street Address _____
(Required for Supplies)

Business Mailing Address _____

City _____ County _____ State _____ ZIP _____

Phone (_____) _____ Fax (_____) _____ E-mail _____

Home Address _____

City _____ County _____ State _____ ZIP _____

Phone (_____) _____ Birth Date _____ Gender _____

Social Security No. _____ National Producer No. _____

Length of time in present community _____. If less than five years, please provide previous address(es).

Please check the appropriate box.

- All commissions are to be paid to me.
- All commissions are to be paid to _____, _____
Agency, Company, or Name Tax ID No.

Please answer all questions. (If YES, include details of who, what, when, and dollar amounts on an additional form.)

	YES	NO
1. Have you ever had an appointment terminated by any insurance company or financial services institution (for reasons other than production)?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you owe any debt or balance to any insurance company or financial services institution that has remained overdue for more than sixty (60) days?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has any state or federal agency ever denied, suspended, revoked, or taken any action against any fiduciary license held or applied for by you, or have you ever voluntarily submitted to any sanction or surrendered any fiduciary license under threat of suspension or revocation of that license?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has any state or federal self-regulatory body of any type (such as National Association of Securities Dealers) ever taken any disciplinary measures against you?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had a claim filed against your Errors and Omissions Coverage, or has any bonding company ever denied, paid out on, or revoked a bond for you?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever been the subject of any civil or administrative proceeding, including one initiated by a state department of insurance?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have any felony charges pending against you, or have you ever pled guilty or <i>nolo contendere</i> to or been convicted of a felony or a crime involving moral turpitude?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have any unsatisfied liens (tax or otherwise) or judgments (civil or otherwise) against you?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you been the subject of a bankruptcy petition or proceeding in the past seven (7) years?	<input type="checkbox"/>	<input type="checkbox"/>

(1) I hereby represent that the answers and statements (“the information”) I am giving Golden Rule Insurance Company and its affiliates (“the Company”) on this application (“PBA”) are correct, complete, and wholly true. (2) I understand the Company will rely on the information as one factor in considering this PBA, and may, at its option, terminate or rescind our resulting business relationship if any of the information is not as I have given it. (3) I give the Company, its employees, agents, and/or contractors permission to direct advertising or promotional phone calls, faxes, and electronic mail to the numbers and addresses I have listed above, as well as any others I provide. This permission continues until specifically revoked by me in writing. (4) I understand this PBA will not be considered until I sign the FCRA Authorization.

Signature _____  Date _____

NOTE: No business may be solicited until all state licensing and appointment and/or contract requirements have been met, and you have been advised of that fact in writing by the Company.

1 How many new individual health applications did you personally write in the past 12 months with all companies combined -- excluding Short Term, Medicare Supplements, and Employer/Group policies? (Check one.)

0 1-3 4-7 8-11 12-20 21-50 51-100 101-200 201+

How many do you plan to write in the next year? (Check one.) More Same Less

2 What type of individual health plans do you personally write most often -- excluding Short Term, Medicare Supplements, and Employer/Group policies? (Check one.)

- Low Deductible Copay Plans** -- Plans with \$1,000 or lower deductible which include doctor office visit copays.
- High Deductible Copay Plans** -- Plans with \$1,250 or higher deductible which include doctor office visit copays.
- Traditional Major Medical Plans** -- Major medical plans that do not include doctor office visit copays.
- HSA Plans** -- Plans that combine medical insurance with a tax-favored savings account.
- Hospital Surgical Plans** -- Lower premium plans which primarily cover major hospital and surgical expenses.
- Other** -- Please specify. _____

3 Please put the number 1 by the company you consider to be your primary source for your new individual health applications and a number 2 by your secondary company. **Please mark 1 and 2 only.**

<input type="checkbox"/> Aetna	<input type="checkbox"/> Anthem Blue Cross/	<input type="checkbox"/> Golden Rule	<input type="checkbox"/> Pacific Care
<input type="checkbox"/> American Community	<input type="checkbox"/> Blue Shield	<input type="checkbox"/> Humana	<input type="checkbox"/> Unicare
<input type="checkbox"/> American Medical Security	<input type="checkbox"/> Celtic	<input type="checkbox"/> John Alden	<input type="checkbox"/> None
<input type="checkbox"/> American Republic	<input type="checkbox"/> Fortis/Time/Assurant	<input type="checkbox"/> Medical Mutual	<input type="checkbox"/> Other _____

4 In the past 12 months, how many of the following products have you written?

Short Term Medical Plans	Medicare Supplements	Health Savings Accounts (HSAs)
<input type="checkbox"/> 0	<input type="checkbox"/> 0	<input type="checkbox"/> 0
<input type="checkbox"/> 1-10	<input type="checkbox"/> 1-10	<input type="checkbox"/> 1-10
<input type="checkbox"/> 11-50	<input type="checkbox"/> 11-50	<input type="checkbox"/> 11-50
<input type="checkbox"/> 51+	<input type="checkbox"/> 51+	<input type="checkbox"/> 51+

5 Which company's individual short-term medical plan(s) do you write? **Please mark 1 and 2 only.**

<input type="checkbox"/> American Community	<input type="checkbox"/> Celtic	<input type="checkbox"/> Healthnet	<input type="checkbox"/> None
<input type="checkbox"/> American Family	<input type="checkbox"/> Fortis/Time/Assurant	<input type="checkbox"/> Humana	<input type="checkbox"/> Other _____
<input type="checkbox"/> Anthem Blue Cross/ Blue Shield	<input type="checkbox"/> Golden Rule	<input type="checkbox"/> Trustmark	
	<input type="checkbox"/> GradMed		

6 Which company's Medicare supplement plan(s) do you write? **Please mark 1 and 2 only.**

<input type="checkbox"/> Anthem Blue Cross/ Blue Shield	<input type="checkbox"/> Continental Life	<input type="checkbox"/> Mutual of Omaha	<input type="checkbox"/> Unicare
	<input type="checkbox"/> Golden Rule	<input type="checkbox"/> Standard Life	<input type="checkbox"/> Other _____

Sign and Return this Page to Golden Rule
AGENCY INDEPENDENT BROKER'S CONTRACT
SIGNATURE PAGE

I acknowledge and agree that:

- (a) I have received a copy of the Independent Broker's Contract Form (IBC-0410), consisting of this page and four (4) other pages, as well as the Rules and Regulations (Rules-0410), which are fully incorporated by reference and made a part of the *Contract*;
- (b) I have read, understood, and agreed to each and every term of this *Contract*; and
- (c) This *Contract* will not be in effect until such time as the *Company* has countersigned this Signature Page and attached the appropriate *Commission Schedule(s)*.

IMPORTANT Brokers and Agencies must sign separate signature pages.
 If you work for an agency and the agency is also seeking an appointment with Golden Rule Insurance Company, a separate agreement must be completed and signed by the individual broker and an agency representative.

For Broker/Agency

Print or type *Your Name* (or agency's name if this signature page is for your agency)

SIGN HERE

X

Signature

(Print *Your Name* if signing as the agency representative for your agency)

TAX ID – Title (if signing as the agency's representative)

Date

BENEFICIARY DESIGNATIONS (See 3.9):

Name

Address

Relationship

Primary Beneficiary(ies)

Contingent Beneficiary(ies)

FOR HOME OFFICE USE ONLY
EXECUTED ON BEHALF OF GOLDEN RULE INSURANCE COMPANY

BY:

Name

X

Signature

Date

This agreement shall take effect as of _____ Producer No. _____

INDEPENDENT BROKER'S CONTRACT

GOLDEN RULE INSURANCE COMPANY of Lawrenceville, Illinois (herein called the "Company", "We", "Us", or "Our") and *You* do hereby agree as follows:

DEFINITIONS

The following terms have the meanings set forth below:

"*Broker of Record*" refers to the person shown as licensed broker on the relevant application for an *Insurance Product*. If more than one person is shown on the application, credit will be divided into a maximum of two equal shares. After the first year, the *Broker of Record* may be changed, but only upon receipt and acceptance by *Us* of a written request from the *Client*.

"*Contract*" refers to this Independent Broker's Contract, including the Rules and Regulations, which are incorporated by reference.

"*Clients*" refers to *Our Insureds*, policyholders, certificateholders, payors, MET employers, or applicants for whom *You* are *Broker of Record*.

"*Commission Schedule*" refers to the schedule as initially attached to this *Contract* or as modified by written notice from the *Company*.

"*Insured*" refers to any person covered under an *Insurance Product*.

"*Insurance Products*" refers to the insurance policies, certificates, contracts, plans, or other evidence of coverage available from *Us*, including annuity contracts.

"*PBA*" refers to the Prospective Broker Application.

"*You*" and "*Your*" refer to the party that has executed this *Contract*. If *You* are an agency or other entity, *You* act only through *Your* agents, employees, and representatives. Any provisions that could only apply to a natural person will not apply to *You*. All other provisions will apply to *You*.

"*Your Sub-Brokers*" refers to brokers: (1) who have designated *You* as the party to be paid on their *PBAs*; and (2) authorized by *Us* to submit applications.

PART I -- YOUR AUTHORITY

1.1 General Authority. *You* have the authority, responsibility, and rights stated in this *Contract*. Subject to all terms of this *Contract* and any applicable state or federal laws, *You* are authorized to:

- (a) Obtain and submit applications for *Insurance Products* to *Us* for *Our* consideration on behalf of persons for whom *You* are acting as broker, but only if the *Insurance Product* is: (1) named in the *Commission Schedule*; (2) offered in those states in which *You* are authorized and/or appointed; and (3) one for which *You* understand the materials provided by *Us*, and have completed any required product training.
- (b) Collect initial premiums in exchange for official receipts furnished by *Us*. *You* do not have the exclusive right to submit applications on behalf of prospective *Clients* for any *Insurance Product*.
- (c) Submit *PBAs* for prospective sub-brokers. If *You* are a sub-broker, *You* may not have sub-brokers.

1.2 Independent Status. *You* are an independent contractor relative to the *Company*. Although this *Contract* entitles *You* to submit applications to the *Company* on behalf of prospective *Clients*, *You* shall not represent to anyone that *You* act on behalf of the *Company*, except as expressly set forth in this *Contract*.

Nothing contained in this *Contract*, or any written material or correspondence of the *Company*, shall be construed to create an employer-employee or principal-agent relationship between *You* and the *Company*. The parties recognize that:

- (a) Due to a particular state's licensing requirements, *You* may be appointed in that state as an "agent"; and

- (b) From time to time the *Company* or others may refer to *You* as an “agent.” These references may occur because of the general use of these words in everyday vocabulary.

It is expressly intended and agreed that *You* are an independent contractor, acting as the agent of *Your Clients* and not as *Our* agent. *You* are free to exercise *Your* own judgment as to the time, place, and manner of dealing with *Your Clients* and potential *Clients*.

- 1.3 Unauthorized Acts.** *You* are prohibited from engaging in any act not expressly authorized by *Us*. Unauthorized acts specifically set forth in the Rules and Regulations may result in termination of this *Contract* and forfeiture of future compensation. *We* may seek any other remedy *We* deem appropriate.

PART II -- YOUR DUTIES

- 2.1 Compliance with Company Rules.** *You* will comply with the Rules and Regulations incorporated by reference into this *Contract*, as well as any written changes provided to *You*.
- 2.2 Your Sub-Brokers.** *You* are responsible for the acts and omissions of *Your Sub-Brokers* as though they were *Your* acts and omissions. Therefore, *You* must train and supervise *Your Sub-Brokers*. *Your Sub-Brokers* do not have any authority not granted to *You*. Whatever is required of *You* is also required of *Your Sub-Brokers*.
- 2.3 Licensing and Appointment.** In order to submit applications for *Insurance Products*, *You* must be licensed as required by law, and authorized and/or appointed by *Us*. In states that send renewal license information directly to the licensee, it is *Your* responsibility to furnish *Us* with a copy of *Your* renewal licenses. Renewal appointment fees or other fees for *You* and *Your Sub-Brokers* may be withheld from compensation.
- 2.4 Errors and Omissions Coverage.** *We* reserve the right, as a condition for submission of applications, to require that *You* obtain Errors and Omissions insurance coverage from a carrier satisfactory to *Us* of the type and in the amounts specified by the *Company*. *You* must notify *Us* of any changes in *Your* Errors and Omissions insurance coverage.

- 2.5 Trust Fund.** All collections made by *You* shall be kept entirely separate and distinct from other funds. *You* shall pay these collections over to *Us* within three (3) business days. *You* shall not make use of any of these funds. If *You* withhold any funds, policies, receipts, or other property belonging to the *Company* or a *Client*, this *Contract* shall be immediately terminable by the *Company* without notice and all compensation accruing to *You* shall be forfeited in accordance with 3.6.

- 2.6 Product Delivery.** *You* shall promptly deliver all *Insurance Products* in accordance with the Rules and Regulations. Without the specific written approval of the *Company*, *You* are expressly forbidden to deliver any *Insurance Products* to a *Client*.

- (a) Without securing the full first premium.
- (b) When, to *Your* knowledge, the *Client* has received medical treatment, consultation, or medication; has contracted any illness or disease; has suffered any injury or mental or physical impairment since making application for insurance; or there has been any other change in circumstances of the *Client* from the circumstances included in the application.
- (c) When, to *Your* knowledge, a misrepresentation has been made on the application.

- 2.7 Taxes.** *You* are responsible for all occupational, income, and municipal taxes for *You*. All state premium taxes will be paid by *Us*.

- 2.8 Advertising Materials.** All advertising material that uses or includes the name of the *Company* or that describes *Our Insurance Products* shall not be printed, circulated, or used without *Our* prior written approval. Refer to the Rules and Regulations for specific requirements.

- 2.9 Confidentiality and Privacy.** *We* expect *You* and/or *Your* employees to comply with the confidentiality and privacy of information requirements, as specified in the Rules and Regulations. This 2.9 shall survive termination of the *Contract*.

- 2.10 Cooperation.** If a *Client* notifies *You* of a complaint about *You* or the *Company*, *You* will immediately notify *Us*. If one of *Your Clients*

files a complaint or lawsuit against *You* or the *Company*, *You* will cooperate fully with *Us* by:

- (a) Answering relevant questions under oath; and
- (b) Furnishing copies of relevant documents that pertain to the matter or other assistance reasonably required to resolve the matter.

PART III -- COMPENSATION

3.1 Commissions. *We* pay commissions on *Insurance Products*. The commissions will be based on the *Commission Schedule(s)* attached by the *Company* and the *Broker of Record* on the date the premium is received and credited by *Us*. If *You* are a sub-broker, commissions on *Your* business will be based on the commission schedule of the party designated by *You* to receive *Your* commissions on *Your PBA*. *We* may change this schedule at any time, but changes will only apply to applications written after *We* mail notice of the change to *You*.

3.2 Payment. Commissions will be paid to *You* unless *You* are a sub-broker. Commissions will accumulate until at least \$100 is payable. *You* may assign commissions only to a properly licensed broker appointed and/or authorized by *Us*. *We* will honor an appropriate court order or notice of levy in the event of garnishment or levy.

3.3 Your Sub-Brokers. *You* are solely responsible for the compensation of *Your Sub-Brokers*. *You* agree to indemnify and hold the *Company* harmless from any losses, costs, liabilities, or damages that are incurred by *Us* as a result of *Your* failure to promptly or properly compensate these persons.

3.4 Reservation of Rights. The *Company* reserves the right to determine:

- (a) Whether compensation will be paid and, if so, to whom it will be paid, on reinstated or converted *Insurance Products* and on *Insurance Products* that in *Our* judgment are replacements of existing *Company Insurance Products*.
- (b) The amount of compensation to be paid on *Insurance Products* not now covered in the *Commission Schedule(s)*.

- (c) Whom to pay if there is a dispute between *You* and another broker over compensation, but not between *You* and *Your Sub-Brokers*.

3.5 Chargebacks, Setoffs, and Deficits. If *We* return premium for any reason, the commissions on that premium will be deducted from *Your* commissions. *We* may set off any debt owed by *You* to *Us* against any amount owed by *Us* to *You*. If *You* owe *Us* more than *We* owe *You*, *You* shall repay *Us* any deficit amount, within 30 days of demand.

3.6 Forfeiture of Future Compensation. No further compensation will be due or payable if *You* or *Your Sub-Brokers* commit any unauthorized acts under Part II of the Rules and Regulations. This 3.6 survives termination of this *Contract*.

3.7 Termination of Compensation. If this *Contract* is terminated for any reason other than pursuant to 4.1(a) and subject to all other terms of this *Contract*, the *Company* will continue to pay any commissions owed to *You* until:

- (a) *Your* death and the death of all designated beneficiaries (or dissolution if *You* are a business entity);
- (b) These payments have been made for five (5) years; or
- (c) Commissions otherwise payable to *You* in any calendar year are \$1,000 or less.

3.8 Conclusive Accountings. If *You* are not a sub-broker, *We* will provide or make available to *You* a periodic statement of all compensation due and payable to *You* with each commission payment. Unless *You* file a written objection to the statement within sixty (60) days from the date of the mailing or posting of the statement, that statement shall be deemed conclusively correct and *You* waive any right to contest the statement.

3.9 Beneficiaries. *Your* primary and contingent beneficiary designations are shown on the Signature Page of this *Contract*. If no designations are shown, *Your* estate will be *Your* beneficiary. *We* will follow *Our* usual procedures concerning payments to beneficiaries and changes in beneficiary designations.

PART IV -- GENERAL PROVISIONS

4.1 Termination of *Contract*.

- (a) **Termination for Cause.** *We* may effect an immediate termination of this *Contract* and revoke all *Your* rights and privileges by written notice to *You*, if *You* fail to:
 - (i) Comply with the terms and conditions of *Your Contract*, including a failure to abide by the Rules and Regulations.
 - (ii) Obtain or maintain any required insurance license in any state.
- (b) **Termination without Cause.** This *Contract* may also be terminated without cause by either party upon at least thirty (30) days written notice to the other party.
- (c) **Automatic Termination of Sub-Broker.** If *You* are a sub-broker, this *Contract* will terminate automatically and without notice if the contract between *Us* and the party designated by *You* on *Your PBA* is terminated.

4.2 Reservation of Rights.

Without terminating this *Contract*, *We* reserve all *Our* rights not expressly in conflict with this *Contract*, including the right to:

- (a) Authorize or terminate authorization of some of *Your Sub-Brokers* and not others.
- (b) Refuse to accept business from any of *Your Sub-Brokers*.
- (c) Discontinue acceptance of applications for any *Insurance Product*.
- (d) Withdraw from doing business in any state or area.

4.3 Good Faith.

The parties agree to perform all duties under this *Contract* in utmost good faith.

4.4 Indemnification.

You agree to indemnify and hold the *Company* harmless from any and all "loss" incurred by *Us* as a result of any act or omission that is:

- (a) In violation of this *Contract*, or
- (b) Negligent or intentional misconduct; and

- (c) Committed by *You*, *Your Sub-Brokers*, and/or *Your* employees.

As used here, "loss" includes, but is not limited to, court costs, any claims or benefits paid pursuant to judgment or reasonable settlement, and all reasonable attorneys' fees and expenses incurred by *Us* in defending and/or settling any claim against *Us*, or in pursuing recovery from *You*, *Your Sub-Brokers*, and/or *Your* employees.

4.5 Modification of *Contract*.

This *Contract* may only be modified in writing signed by a duly authorized representative of the *Company*. *You* will be deemed to have accepted any changes (other than those described in 2.1 and 3.1), unless *You* notify the *Company* in writing to the contrary within thirty (30) days of receipt of the *Contract*-change notice.

4.6 Non-Waiver.

Forbearance, neglect, or failure of the *Company* to enforce any or all of the provisions of this *Contract* or to insist on strict compliance by *You* or *Your Sub-Brokers*, shall not be construed as a waiver of any of *Our* rights or privileges.

4.7 Entire Agreement.

This *Contract*, together with all amendments and attachments, including the Rules and Regulations and the *Commission Schedule(s)*, sets forth the entire understanding between *You* and *Us*. This *Contract* supersedes all prior agreements, arrangements, and communications, whether oral or written, with respect to the subject matter.

4.8 Notices.

Any notice required by this *Contract* shall be sufficient and effective upon deposit in the U.S. mail, postage prepaid, and addressed to *You* at *Your* last known address shown on the *Company's* records.

4.9 Choice of Law.

This *Contract* will be construed in accordance with the laws of the state of Illinois without reference to Illinois conflicts-of-law provisions.

4.10 Headings and Titles.

The headings and titles used in this *Contract* are non-substantive and for reference only.

4.11 Severability.

If any provision of this *Contract* is held invalid for any reason, the remainder of this *Contract* shall not be affected.



Golden Rule Insurance Company
Home Office
712 Eleventh Street
Lawrenceville, Illinois 62439

RULES AND REGULATIONS for GOLDEN RULE INSURANCE COMPANY INDEPENDENT BROKERS

Read and keep this document and all other notices where they can be referred to as questions or issues arise. Revisions, additions, or deletions to these Rules and Regulations will be deemed to be in *Your* possession seven days after they have been mailed to *You*.

DEFINITIONS

The following terms have the meanings set forth below:

"Broker of Record" refers to the person shown as licensed broker on the relevant application for an *Insurance Product*. If more than one person is shown on the application, credit will be divided into a maximum of two equal shares. After the first year, the *Broker of Record* may be changed, but only upon receipt and acceptance by *Us* of a written request from the *Client*.

"Company", *"We"*, *"Us"*, or *"Our"* refers to Golden Rule Insurance Company.

"Clients" refers to *Our Insureds*, policyholders, certificateholders, payors, MET employers, or applicants for whom *You* are *Broker of Record*.

"Insured" refers to any person covered under an *Insurance Product*.

"Insurance Products" refers to the insurance policies, certificates, contracts, plans, or other evidence of coverage available from *Us*, including annuity contracts.

"PBA" refers to the Prospective Broker Application.

"You" and *"Your"* refer to the party which has received this document. If *You* are an agency or other entity, *You* act only through *Your* agents, employees, and representatives. Any provisions that could only apply to a natural person will not apply to *You*. All other provisions will apply to *You*.

PART I -- GENERAL RULES

1.1 To maintain *Our* good reputation and *Yours*, *You* must comply with all applicable statutes, ordinances, rules, and regulations of all federal, state, municipal, and other regulatory agencies or authorities.

1.2 While *You* are free to give *Your Clients* good, honest advice, *Your* authority to act on *Our* behalf is limited.

You may not, under any circumstances, obligate or bind the *Company* in any manner, such as:

- (a) Issuing binders;
- (b) Field underwriting or determining eligibility; or
- (c) Offering personal assurances concerning issues of underwriting, claim resolution, or coverage.

Your relationship with *Us* is that of an independent contractor. *You* should keep *Us* informed of the following information: *Your* address, telephone number, and states in which *You* are licensed. All materials furnished to *You*, including rate manuals (either in disk form or hard copy), must be returned upon request. Such material may also be considered *Our* proprietary information, and *Your* disclosure of such information is prohibited. If *You* are in doubt as to what material may be disclosed, please contact *Us*.

PART II -- UNAUTHORIZED ACTS

You are prohibited from engaging in any act not expressly authorized by *Us*. No power or authority shall be implied from the grant or denial of powers specifically mentioned in this document. Unauthorized acts include:

- (a) Incurring any debt or obligation on behalf of *Us*, or waiving any forfeiture.

- (b) Making, altering, or discharging any application, policy, plan, or contract.
- (c) Extending the:
 - (i) Time for payment of any premium or accepting payment of any past-due premium; or
 - (ii) Grace period of any product or waiving any grace-period premium.
- (d) Waiving and/or excluding from any application any information including, but not limited to, information pertaining to the health, weight, height, age, residence, past or present physical, mental, or other medical conditions of a *Client*, or any other information that might be required to be disclosed by the *Client*, when that information is disclosed or otherwise known to *You*.
- (e) Receiving any money due or to become due to *Us*, except the first premium or first premium installment on applications submitted by *You*.
- (f) Representing the *Company* in any manner except as authorized by *Us*.
- (g) Signing as *Broker of Record* any application not directly solicited by *You*. *You* shall not sign any application that has been solicited by any other person. *You* may sign only applications solicited by *You*.
- (h) Completing any part of a health insurance application, except premium and broker information, unless otherwise mandated by state law.
- (i) Using any marketing materials that refer to *Our Insurance Products* without *Our* prior written approval.
- (j) Charging a service fee to the *Client* for services provided in soliciting and/or servicing one of *Our Insurance Products*.
- (k) Engaging in unfair and deceptive practices in violation of federal and/or state laws. These practices include misrepresentations, false information, defamation, boycott, coercion, intimidation, false

statements, false entries, unfair discrimination, rebates, and unfair financial planning practices.

- (l) Engaging in unfair competition based on the elements of price, quality, and service under federal or state laws. This includes unsuitable placement, bashing, and making disparaging remarks regarding *Us* or another carrier.
- (m) Perpetrating any fraud or deceit upon a *Client* or *Us*.
- (n) Misapplying or embezzling funds belonging to a *Client* or *Us*. If no policy, plan, or contract is issued on an application, then the whole amount of monies collected by *You* shall be returned to the *Client* within three (3) working days after receipt of notice of nonissue.
- (o) Withholding any funds, policies, receipts, supplies, or equipment belonging to *Us* after *We* have made a demand for them.
- (p) Improperly inducing or influencing *Clients* to relinquish their *Insurance Products* with *Us*.

If *You* engage in any unauthorized act, *We* may terminate *Your* relationship and declare *Your* future compensation forfeited. *We* may also seek any other remedy *We* deem appropriate. This Part II shall survive termination of any contractual relationship.

PART III -- LICENSING

- 3.1** *We* require that *Your* licensing be complete before *You* submit any application to *Us*. *We* will notify *You* when *You* are authorized and/or appointed, and *You* may begin offering applications for *Our* products.
- 3.2** In states that send renewal license information directly to the licensee, it is very important that *You* furnish *Us* with a copy of *Your* renewal license. Unless *Your* current license is on file with *Us*, any application *You* submit will be returned to *You*.
- 3.3** *You* may verify *Your* appointment status and authorization to offer *Our* products by contacting *Our* Marketing Service Center.

PART IV -- APPLICATIONS, PREMIUMS, AND UNDERWRITING

- 4.1 When submitting applications to *Us*, please ensure that the *Client* accurately completes all forms, unless the form is specifically designed to be completed by *You*. Either way, be sure the *Client* carefully reviews the completed application prior to signing and dating it. Never allow a *Client* to sign a blank or an incomplete application.
- 4.2 All applications must be submitted the earlier of: (a) three (3) business days after *You* receive the application from the *Client*; or (b) six (6) business days after the application is completed and signed by the *Client*.
- 4.3 Applications more than fifteen (15) days old when received by *Us* will be returned. The *Client* must date applications on the date the application is signed.
- 4.4 We do not accept COD health business or trial applications. Any submissions without the initial premium will be returned.
- 4.5 We will accept COD life business only in the following situations:
- (a) Cases of life insurance in which the aggregate amount of the life insurance in force or applied for with the *Company* will equal or exceed \$300,000.
 - (b) Cases of life insurance in which any person to be covered has experienced stroke, heart attack, diabetes, or cancer (other than skin cancer).
 - (c) If the insurance product will be funded via a Section 1035 Exchange (in which case the tax form must be submitted with the application).
- 4.6 Unless otherwise instructed by *Us* on the application, premium checks should be made payable to the *Company* and submitted with the application. Partial payments cannot be accepted unless specifically provided for in the product information.
- 4.7 Only initial premiums are to be collected and submitted with the application. Subsequent premiums will be billed directly by *Us*, and the *Client* will make all payments directly to the *Company*, unless otherwise instructed by *Us*.

If the first year's premium is payable in installments, *You* will collect only the first installment.

- 4.8 With regard to a health product for individuals and small groups, the earliest possible effective date is the date set forth in the Conditions Prior to Coverage provision for that product.
- 4.9 Do not submit altered applications.
- 4.10 Coverage restriction riders attached to any issued *Insurance Product* will be reviewed upon written request if:
- (a) Six months have elapsed for one-year riders; or
 - (b) One year has elapsed for riders that have a duration of more than one year.

PART V -- CONFIDENTIALITY AND PRIVACY OF INFORMATION

- 5.1 As used in this Part V, all references to *You* will include any of *Your* employees, sub-brokers, or other representatives.
- 5.2 *You* may be provided with or have access to information which *We* consider confidential and proprietary ("Confidential Information"), including, but not limited to, pricing, rates, computer programs, and product information. *You* will hold in confidence and not use or disclose any Confidential Information. This shall not apply to the Confidential Information if it:
- (a) Is readily available to the public without restriction through no fault of *Yours*.
 - (b) Is received without restriction from a third party lawfully in possession of and lawfully empowered to disclose this information.
 - (c) Was rightfully in *Your* possession without restriction prior to its disclosure, or was independently developed by *You* without access to such Confidential Information.
- 5.3 *You* may be provided with or receive "Protected Information." "Protected Information" shall be defined to include, but is not limited to, "nonpublic personal information" and "individually identifiable health information" as currently used in 15 U.S.C. § 6809 and 45

C.F.R. § 164.501 and as they are subsequently updated, amended, or revised.

5.4 Pursuant to this agreement, *You* will provide services for *Us* that involve the use and receipt of Protected Information. Except as otherwise specified herein, *You* may use the Protected Information as necessary to perform *Your* obligations under this agreement. All other uses not authorized by this agreement are prohibited. In the event *You* disclose Protected Information which is not authorized by this agreement, *You* agree to inform *Us* in writing of such disclosure as soon as *You* discover it.

5.5 Either party may terminate this agreement at any time with at least ten (10) days prior written notice for an uncorrected material breach of this Part V, provided the breaching party was allowed a reasonable opportunity to remedy the material breach, and it was not corrected during that time. Upon termination of this agreement, the breaching party shall:

- (a) Destroy or return, the Protected Information in the breaching party's possession and retain no copies (which shall mean destroying all back-up tapes), if it is feasible to do so. If not feasible, provide notification to the other party in writing; and
- (b) Recover any Protected Information in the possession of employees. If it is infeasible for *Us* or *You* to obtain any Protected Information from any employee, *We*, or *You*, must provide a written explanation and require the employees to agree to extend any and all protections, limitations, and restrictions contained in this paragraph to any Protected Information retained after the termination.

5.6 Responsibilities of *You* and the *Company*.

With regard to the use and/or disclosure of Protected Information, *You* and the *Company* hereby agree to do the following:

- (a) Use and/or disclose the Protected Information only as permitted or required by this agreement and/or by law.
- (b) Put into practice administrative, physical, and technical safeguards that reasonably and

appropriately protect the confidentiality, integrity, and availability of the Protected Information that *You* create, receive, maintain, or transmit on behalf of *Us*.

- (c) Require all employees that receive, use, or have access to Protected Information to agree in writing to adhere to the same restrictions and conditions contained in this Part V.
- (d) Make all records, books, agreements, policies, and procedures relating to the use and/or disclosure of Protected Information available to regulatory authorities for purposes of determining compliance with the Privacy Laws, subject to attorney-client and other applicable legal privileges.
- (e) Upon request, agree to provide access to the Protected Information to the *Insured* to whom it relates (or his or her authorized representative).
- (f) Upon request, agree to make any amendment(s) to the Protected Information.
- (g) Upon request from *Us*, provide such information to respond to a request by an *Insured* for an accounting of the disclosures of the *Insured's* Protected Information.
- (h) Unless authorized in writing by *Your* client, *You* agree not to further disclose account numbers to conduct telemarketing, direct-mail marketing, or other electronic-mail marketing to *Your* client.

5.7 *You* and the *Company* shall not be obligated under this Part V, if the Protected Information:

- (a) Is or has become readily publicly available without restriction.
- (b) Is received without restriction from a third party lawfully in possession of and lawfully empowered to disclose such information.
- (c) Was rightfully in *Your* possession or *Ours* without restriction prior to its disclosure or was independently developed by *You* or *Us*.

PART VI -- COMMISSIONS

- 6.1 Commissions are paid on business actually issued through the last day of the preceding month. After *Your* first year as a broker, commission payments will be left to accumulate until at least \$100 in commissions is payable.
- 6.2 Commission is not paid on new applications until the *Insurance Product* has been issued and *We* have received the premium.
- 6.3 Please wait at least sixty (60) days following submission of an application to inquire about unpaid commissions. *Your* inquiry should be directed to *Our* Marketing Service Center.

PART VII -- ADVERTISING

- 7.1 All advertising material used by *You* that uses or includes *Our* name or that describes *Insurance Products* offered by *Us* shall be submitted to *Us* prior to use and shall not be printed, circulated, or used without *Our* prior written approval. Advertising material includes, but is not limited to, materials provided to potential *Clients*, the general public, or existing *Clients* (when offering or promoting a change in existing coverage). Types of advertising material include, but are not limited to, brochures, fliers, cards, letters, television or radio scripts, booklets, illustrations, videos, computer-generated media (such as the Internet), prepared sales talks, presentations, telephone listings, signs, magazines, newsletters, and newspapers.
- 7.2 *You* may not change the format or content of *Our* advertising material, nor may *You* incorporate another company's advertising material into or with *Our* advertising material.
- 7.3 *Our* advertising material may not be reproduced or distributed on the Internet, through E-mail, or by any other electronic means without *Our* prior written approval.
- 7.4 Any advertising materials available to *You* through the *Company's* Broker Internet Service, including, but not limited to, brochures or other information, may not be distributed by *You* to any persons other than *Your* prospective *Clients*.
- 7.5 *You* may not use the *Company's* name, trademark, service mark, or product name or make reference to such trademark, service mark, or

product name in any advertising materials, including, but not limited to, building directories, office doors, or signs. *You* are prohibited from using the *Company's* name or logo in any way that might imply a relationship between *You* and *Us* other than the relationship of an independent contractor.

PART VIII -- CLAIMS

- 8.1 *We* make every effort to assure fast, accurate, and fair claims handling. *You* can best serve *Your Clients* by encouraging the claimants to cooperate in the collection of all medical records necessary for a complete and proper claim.
- 8.2 *You* shall not offer opinions about claims to *Insured's* or other persons. Decisions on all claims will be made by the Claims Department based on information submitted by the *Insured* and the providers of medical services.

INFORMATION SOURCES

Claims/Account Servicing: Should *You* receive a question from an *Insured* or a provider regarding a health claim, please refer him/her to *Our* Client Services Division at the location and telephone number shown on the back of the *Insurance Product* identification card.

Marketing Opportunities: Refer all marketing questions and issues to *Our* Marketing Service Center. Please stay within the designated communication channels so that duplication of efforts is avoided.

SUBSTITUTE FORM W-9 TAXPAYER IDENTIFICATION NUMBER REQUEST

Please complete the following information. We are required by law to obtain this information from you when making a reportable payment to you. If you do not provide us with this information, your payments may be subject to a 28% federal income tax back-up withholding. Also, if you do not provide us with this information, you may be subject to a \$50 penalty imposed by the Internal Revenue Service under Section 6723.

I. TAX STATUS: Complete the information requested for the section that corresponds to your tax status.

Individual -- Please list your full name and Social Security Number.

Name: _____

Social Security Number: _____

Sole Proprietor -- Please list the business owner's full name and Social Security Number.

Business Owner's Name: _____

Business Owner's Social Security Number: _____

Doing Business As: _____

Partnership -- Please list the legal name of the partnership, the partnership's Employer Identification Number, and the "doing business as" business name (if different from the legal).

Partnership's Legal Name: _____

Partnership's Employer Identification Number: _____

Doing Business As: _____

Corporation -- Please list the legal name of the corporation (do not abbreviate), the corporation's Employer Identification Number, and the "doing business as" business name (if different from the legal).

Corporation's Legal Name: _____

Corporation's Employer Identification Number: _____

Doing Business As: _____

II. ADDRESS: Please fill in your current address below:

III. EXEMPTION: If exempt from Form 1099 reporting, please list qualifying exemption:

Qualifying Exemption: _____

IV. CERTIFICATION: I certify under penalty of perjury that the Tax Identification Number I have provided is correct.

Person Completing This Form:

Signature: _____ 

Date _____ Phone: () _____

Direct Deposit is FAST!

- Fits your busy schedule.
- Address changes/mail will not delay payment.
- Statements available online (up to 12 months).
- Trips to deposit your checks are eliminated.

AUTHORIZATION AND AGREEMENT FOR ELECTRONIC DIRECT DEPOSIT

By completing and signing this form, I hereby authorize Golden Rule Insurance Company and/or American Medical Security Life Insurance Company and/or PacifiCare Health Plan Administrators, Inc., and/or United Healthcare Insurance Company, and/or any affiliate company (collectively, "the Company") to electronically deposit (and the Financial Institution to accept) my future commissions, and other compensation payable in cash (collectively "Commissions"), into the account listed below. I understand the deposits will be based upon, and are subject to, the terms and conditions of my compensation agreement(s) with the Company, and that the amounts of the deposits will fluctuate. I also authorize adjustment of any deposit made in error.

I understand that the Company will make every effort to deposit Commissions on the same working day(s) of each month following each commission cycle, but that the Company cannot and does not guarantee that will occur. I understand that other compensation, depending upon its nature, may not be payable or paid according to any schedule. I agree to hold the Company harmless for any charges or damages, direct or indirect, related to the amount of, or the timing of, the deposits or adjustments.

I agree to receive and view my commission statements via the Internet-based system(s) provided by the Company, and that making them available in this manner satisfies the Company's periodic statement and/or accounting obligations.

I understand that the Company will make reasonable efforts to timely process this authorization, or any changes to it, including revocation. However, I understand that such processing may not occur prior to the next deposit. I therefore agree that the prior compensation arrangements between us, if any, will continue until this authorization is processed. I agree to provide the Company immediate written notice of any change(s) in the information entered below, and both the Company and the Financial Institution advance written notice of revocation of this authorization.

SIGN HERE
PRINT HERE

Signature

Printed Name

Date

Producer Number

Account Holder Name (as it appears on the account) _____

Financial Institution _____

Address _____

City _____ State _____ ZIP Code _____

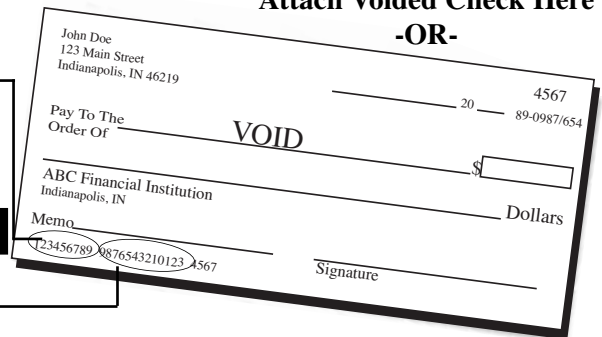
Phone (including area code) _____

1. Write your *nine*-digit routing number for your financial institution here:

2. Write your account number here:

(You can also find your account number by looking on your most recent financial institution statement.)

Attach Voided Check Here
-OR-



Appointment Fee Credit Card Authorization Form

Producer's NPN (National Producer Number) (If known): _____

I authorize Golden Rule to bill my VISA/MASTERCARD account.

VISA MASTERCARD Exp. Date: _____ / _____ Amount Charged:

Security Code:

(last 3 digits in signature line)

X _____ 

Printed Name (Please print legibly)

Telephone Number *Required*

X _____ 

Signature of Cardholder

Payment is for: (Please check one)	<input type="checkbox"/> Appointment Fee
	<input type="checkbox"/> Renewal Fee
	<input type="checkbox"/> Charge Back

NOTE: Your resident appointment fee is refundable upon the submission of your first Golden Rule application.

State Resident and Nonresident Appointment Fees

If payment is for appointment fee(s), please circle the state and fee to be charged.

These fees are charged by each state's department of insurance and are subject to change.

State	Resident	Non-resident	State	Resident	Non-resident
Alabama	<input type="checkbox"/> \$30	<input type="checkbox"/> \$30	Missouri	<input type="checkbox"/> N/A	<input type="checkbox"/> N/A
Alaska	<input type="checkbox"/> No Fee	<input type="checkbox"/> No Fee	Montana	<input type="checkbox"/> No Fee	<input type="checkbox"/> No Fee
Arizona	<input type="checkbox"/> N/A	<input type="checkbox"/> N/A	Nebraska	<input type="checkbox"/> \$8	<input type="checkbox"/> \$8
Arkansas	<input type="checkbox"/> Fee Paid*	<input type="checkbox"/> Fee Paid*	New Hampshire	<input type="checkbox"/> \$25	<input type="checkbox"/> \$25
California	<input type="checkbox"/> \$24	<input type="checkbox"/> \$24	New Jersey	<input type="checkbox"/> No Fee	<input type="checkbox"/> No Fee
Colorado	<input type="checkbox"/> N/A	<input type="checkbox"/> N/A	New Mexico	<input type="checkbox"/> \$23	<input type="checkbox"/> \$23
Connecticut	<input type="checkbox"/> No Fee	<input type="checkbox"/> No Fee	Nevada	<input type="checkbox"/> \$15	<input type="checkbox"/> \$15
Delaware	<input type="checkbox"/> \$25	<input type="checkbox"/> \$25	North Carolina	<input type="checkbox"/> \$20 + \$10**	<input type="checkbox"/> \$20 + \$10**
District of Columbia	<input type="checkbox"/> \$25	<input type="checkbox"/> \$25	North Dakota	<input type="checkbox"/> \$10	<input type="checkbox"/> \$10
Florida	<input type="checkbox"/> \$60	<input type="checkbox"/> \$60***	Ohio	<input type="checkbox"/> \$20	<input type="checkbox"/> \$20
Georgia	<input type="checkbox"/> \$10	<input type="checkbox"/> \$10	Oklahoma	<input type="checkbox"/> \$40	<input type="checkbox"/> \$40
Hawaii	<input type="checkbox"/> No Fee	<input type="checkbox"/> No Fee	Oregon	<input type="checkbox"/> No Fee	<input type="checkbox"/> No Fee
Idaho	<input type="checkbox"/> No Fee	<input type="checkbox"/> No Fee	Pennsylvania	<input type="checkbox"/> \$15	<input type="checkbox"/> \$15
Illinois	<input type="checkbox"/> N/A	<input type="checkbox"/> N/A	Rhode Island	<input type="checkbox"/> N/A	<input type="checkbox"/> N/A
Indiana	<input type="checkbox"/> N/A	<input type="checkbox"/> N/A	South Carolina	<input type="checkbox"/> Fee Paid*	<input type="checkbox"/> Fee Paid*
Iowa	<input type="checkbox"/> No Fee	<input type="checkbox"/> No Fee	South Dakota	<input type="checkbox"/> \$10	<input type="checkbox"/> \$20
Kansas	<input type="checkbox"/> \$5	<input type="checkbox"/> \$5	Tennessee	<input type="checkbox"/> \$15	<input type="checkbox"/> \$15
Kentucky	<input type="checkbox"/> \$40/Agency \$100	<input type="checkbox"/> \$50/Agency \$120	Texas	<input type="checkbox"/> \$10	<input type="checkbox"/> \$10
Louisiana	<input type="checkbox"/> \$20	<input type="checkbox"/> \$20	Utah	<input type="checkbox"/> No Fee	<input type="checkbox"/> No Fee
Maine	<input type="checkbox"/> \$30	<input type="checkbox"/> \$70	Vermont	<input type="checkbox"/> \$60	<input type="checkbox"/> \$60
Maryland	<input type="checkbox"/> N/A	<input type="checkbox"/> N/A	Virginia	<input type="checkbox"/> \$14	<input type="checkbox"/> \$14
Massachusetts	<input type="checkbox"/> \$75	<input type="checkbox"/> \$75	Washington	<input type="checkbox"/> \$20	<input type="checkbox"/> \$20
Michigan	<input type="checkbox"/> \$5	<input type="checkbox"/> \$5	West Virginia	<input type="checkbox"/> \$25	<input type="checkbox"/> \$25
Minnesota	<input type="checkbox"/> \$10	<input type="checkbox"/> \$10	Wisconsin	<input type="checkbox"/> \$7	<input type="checkbox"/> \$24
Mississippi	<input type="checkbox"/> \$10	<input type="checkbox"/> \$10	Wyoming	<input type="checkbox"/> \$15	<input type="checkbox"/> \$15

* Fee paid by appointing insurance company.

** Add \$10 for Med Supp/LTC appointment.

*** Add \$6 per Florida county.

FAIR CREDIT REPORTING ACT DISCLOSURE and AUTHORIZATION

GOLDEN RULE INSURANCE COMPANY AND ITS AFFILIATED COMPANIES (“THE COMPANY”) MAY OBTAIN A CONSUMER REPORT ABOUT YOU IN CONNECTION WITH YOUR PROSPECTIVE BROKER APPLICATION (“PBA”)

AUTHORIZATION

I authorize the Company to conduct a public records search, and/or to obtain a consumer report and/or investigative consumer report about me from a consumer reporting agency. These reports may concern my credit history, worthiness, standing, and/or capacity. These reports may also concern my character, general reputation, personal characteristics, mode of living, criminal history, motor vehicle record, and other data relevant to the appointment and/or contract process with the Company. I understand the Company will use this data within that process as one factor in considering my PBA.

I understand that if the Company decides not to approve my PBA, and thereby to take adverse action against me because of information contained in any consumer report(s) authorized by my signature on this form, the Company will provide to me:

- A written pre-adverse action disclosure;
- An adverse action notice;
- A copy of any consumer report(s) received and used by the Company;
- A copy of “A Summary of Your Rights Under the Fair Credit Reporting Act”;
- The name, address, and telephone number of any consumer reporting agency that furnished a consumer report about me to them.

I understand that I am entitled to contest the accuracy or completeness of information contained in any consumer report. I understand that I am entitled to receive an additional free copy of any consumer report. I understand that the consumer reporting agency does not itself make any decision regarding my PBA, and the agency cannot explain the Company’s decision to me.

A photocopy or fax copy of this authorization shall be as effective as the original. This authorization remains valid until I revoke it in writing sent to the Company.

 PRINT HERE

Printed Name

Social Security Number

 SIGN HERE

Signature

Date

Home Address

City, State, and ZIP

Golden Rule[®]

A UnitedHealthcare Company