



David A. Crotts & Associates Inc.

LIFE • HEALTH • GROUP • INVESTMENTS

AUTO • HOME • BUSINESS

422 Montague Ave. Suite 7 • Greenwood, SC 29649-1961

Please return, by FAX or mail to:

David A. Crotts & Associates, Inc.

422 Montague Avenue, Suite #7

Greenwood, SC 29649

800-803-7873 -or- 864-223-8788

Fax: 864-229-7392

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





Health Plan Administrators Independence Holding Group

AGENT HEALTH ADDENDUM TO PRODUCER AGREEMENT

This Addendum to the Producer Agreement identifies (1) the line of business for which Producer is appointed and authorized to solicit and procure applications; and (2) the commission schedule applicable to such line of business. HPA and Producer each agrees that this Addendum is subject to all of the terms and conditions of the Producer Agreement and shall be made part of and attached thereto.

Payor: Standard Security Life Insurance Company of New York

Lines of Business: Health & Dental

Schedule of Base Commissions Addendum:

SHORT TERM MEDICAL ¹ / SECURE SAVER Earned Medical Premium	STM LITE MEDICAL ² Earned Medical Premium	SECURE 12 X 3 ³	SECURE DentalOne ⁴
18%	15%	1st Year 18%	1st Year 12%
		2 nd and 3 rd Year 9%	Renewal 9%

¹ SHORT TERM MEDICAL insurance commissions are calculated using the SHORT TERM MEDICAL Premium Rate for the policy at the time of issue. The SHORT TERM MEDICAL premium does not include administration or enrollment fees.

² STM LITE MEDICAL insurance commissions are calculated using the STM LITE MEDICAL Premium Rate for the policy at the time of issue. The STM LITE MEDICAL premium does not include administration or enrollment fees

³ 2nd and 3rd year commissions are based on reapply premium calculated at time of reapply. The 12 X 3 premium calculation does not include administration or enrollment fees

⁴ The commissionable premium calculation for SECURE DentalOne does not include OrthoCare fees, administration or enrollment fees

Agent Signature: _____  Date: _____


GA Name: _____ GA HPA#: _____

MGA Name: _____ MGA HPA#: _____

*Only complete the following if you want HPA to pay your commissions to a Corporation, Agency or another Agent.

COMMISSION ASSIGNMENT FORM *

I _____ (HPA Code #) _____
hereby assign to assignee, _____, all of my right, title, and interest in commissions and/or renewals to which I am now entitled or become entitled, under existing contracts and agreements, heretofore entered into by and between myself and Health Plan Administrators, Inc. I hereby authorize and empower Health Plan Administrators Inc., to pay assignee all commissions and renewals now due or which may accrue under said contracts, for a period of one year from this date and thereafter until such time as I terminate this assignment by written notice to Health Plan Administrators, Inc. I agree that such payments of commissions under my contract, the same as if payment was made directly to me. I hereby covenant and agree that I am the absolute and sole owner of said commissions, free from prior assignment or any encumbrance of any kind or character whatsoever, and that I have full right and lawful authority to sell and transfer the same as aforesaid.

Witness my hand this _____ day of _____, 20____, Agent's Signature _____ 

CAUTION: The person assigning his or her commissions (assignor) will not recover the right to receive any further commissions during the one year period from the date of this assignment unless and until the person to whom such rights are assigned (assignee) releases, in writing, his or her rights to receive such commissions. Please be certain you understand this before signing the form. This instrument may be revoked, in writing, by the Assignor at any time after the one year period.

Address of Assignee _____

Tax I.D.# _____ Assignee's HPA Code # _____



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Payor: United States Fire Insurance Company

Line of Business: Health

Schedule of Base Commissions Addendum:

OVERSEAS TRAVEL MEDICAL¹
15%


¹Overseas Travel Medical commission calculations do not include administration or enrollment fees.

Agent Signature: _____  Date: _____

GA Name: _____ GA HPA#: _____

MGA Name: _____ MGA HPA#: _____

*Only complete the following if you want HPA to pay your commissions to a Corporation, Agency or another Agent.

COMMISSION ASSIGNMENT FORM *	
I _____ (HPA Code #) _____	
hereby assign to assignee, _____, all of my right, title, and interest in commissions and/or renewals to which I am now entitled or become entitled, under existing contracts and agreements, heretofore entered into by and between myself and Health Plan Administrators, Inc. I hereby authorize and empower Health Plan Administrators Inc., to pay assignee all commissions and renewals now due or which may accrue under said contracts, for a period of one year from this date and thereafter until such time as I terminate this assignment by written notice to Health Plan Administrators, Inc. I agree that such payments of commissions under my contract, the same as if payment was made directly to me. I hereby covenant and agree that I am the absolute and sole owner of said commissions, free from prior assignment or any encumbrance of any kind or character whatsoever, and that I have full right and lawful authority to sell and transfer the same as aforesaid.	
Witness my hand this _____ day of _____, 20____, Agent's Signature _____	
<i>CAUTION:</i> The person assigning his or her commissions (assignor) will not recover the right to receive any further commissions during the one year period from the date of this assignment unless and until the person to whom such rights are assigned (assignee) releases, in writing, his or her rights to receive such commissions. Please be certain you understand this before signing the form. This instrument may be revoked, in writing, by the Assignor at any time after the one year period.	
Address of Assignee _____	
Tax I.D.# _____	Assignee's HPA Code # _____



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Product: RX Pay Card

Line of Business: Discount RX

Schedule of Base Commissions Addendum:

RX Pay Card

15%

RX Pay Card commission calculations do not include administration or enrollment fees.

Agent Signature: _____  Date: _____

GA Name: _____ GA HPA#: _____

MGA Name: _____ MGA HPA#: _____

***Only complete the following if you want HPA to pay your commissions to a Corporation, Agency or another Agent.**

COMMISSION ASSIGNMENT FORM *

I _____ (HPA Code #) _____

hereby assign to assignee, _____, all of my right, title, and interest in commissions and/or renewals to which I am now entitled or become entitled, under existing contracts and agreements, heretofore entered into by and between myself and Health Plan Administrators, Inc. I hereby authorize and empower Health Plan Administrators Inc., to pay assignee all commissions and renewals now due or which may accrue under said contracts, for a period of one year from this date and thereafter until such time as I terminate this assignment by written notice to Health Plan Administrators, Inc. I agree that such payments of commissions under my contract, the same as if payment was made directly to me. I hereby covenant and agree that I am the absolute and sole owner of said commissions, free from prior assignment or any encumbrance of any kind or character whatsoever, and that I have full right and lawful authority to sell and transfer the same as aforesaid.

Witness my hand this _____ day of _____, 20____, Agent's Signature _____ 

CAUTION: The person assigning his or her commissions (assignor) will not recover the right to receive any further commissions during the one year period from the date of this assignment unless and until the person to whom such rights are assigned (assignee) releases, in writing, his or her rights to receive such commissions. Please be certain you understand this before signing the form. This instrument may be revoked, in writing, by the Assignor at any time after the one year period.

Address of Assignee _____

Tax I.D.# _____ Assignee's HPA Code # _____



REQUISITION FOR AGENT APPOINTMENT
Health Plan Administrators

Check Type: Agent _____ Agency _____

IDENTIFICATION (please print or type)

Last Name First Name Middle Name Social Security #
Birth Date Place of Birth Age Sex M [] F []

Firm Name (Agency Name Required) Tax I.D. No.

Business Address: Physical Address City State
County Zip Code Telephone No. Fax No.

Resident Address: Physical Address City State
County Zip Code Telephone No. Fax No.

Yes [] I want to take advantage of the online sales tools. My current email address is: _____

List the carrier(s) you want to be appointed with: Standard Security Life Insurance Company of New York []
Madison National Life Insurance Company, Inc. []
Independence American Insurance Company []

List the state(s) in which you are licensed and want to be appointed in:

State License # ; State License # ;
State License # ; State License # ;
State License # ; State License # ;

Name of Manager/Administrator/General Agent: _____

BACKGROUND - Use separate page if needed

1. Do you carry Errors and Omissions Protection? Yes [] No []

Have you ever been:

- (a) convicted of any criminal felony, involving fraud, dishonesty or a breach of trust
(b) convicted of an offense under the Violent Crime Control and Law Enforcement Act of 1994; or
(c) subject to disciplinary proceeding of any federal or state regulatory agency?

Yes [] No [] If yes, provide explanation:

2. Are you bonded? Yes [] No []

3. Has an application for bond ever been declined to you? Yes [] No [] If yes, for what reason?

4. Have you ever been refused any license applied for? Yes [] No [] If yes, what state(s) and why?

5. Has your license ever been cited, suspended or revoked by any state(s)? Yes [] No []

If yes, what state(s) and why? _____

6. Has your appointment ever been terminated involuntarily by an insurance company for reasons other than lack of production? Yes [] No [] If yes, give details:

7. Is any charge by any state currently pending against you or against the agency or any member of the agency? Yes [] No [] If yes, give details:

8. Do you work for or are you under contract to any financial institution such as a bank, a savings and loan association, any subsidiary, affiliate or holding company of such financial institution? Yes [] No [] If yes, please provide the name and address of the financial institution.

9. Are there any outstanding judgments or liens (including state or federal tax liens) against you? Yes [] No [] If yes, give details:

CERTIFICATION/AUTHORIZATION

I certify, under penalty of perjury, that all answers and responses to questions or inquiries contained in this application are true, correct, and complete answers and responses. I further certify that I have read and am familiar with the sections of the insurance code in the state in which I am seeking appointment and that I am withholding no information that would affect my qualification for this appointment. I further certify that I am not prohibited by the Violent Crime Control and Law Enforcement Act of 1994 from engaging in the business of insurance or that I have obtained consent from the appropriate insurance regulator to do so.

I also authorize the Insurance Company to order an investigative report as may be required. I understand that information for the report may be secured from financial sources, and/or public records, or personal interviews with third parties, such as family members, business associates, and/or others with whom I am acquainted. This inquiry may include information as to my character, general reputation, personal characteristics, mode of living, or educational background. I understand that I have the right to make a written request within a reasonable period of time for a complete and accurate disclosure of this information if I so desire.

*By signing below I am giving HPA prior written express invitation and permission to transmit facsimile and email advertisements to me.

*The agent has no authority to act on behalf of the Insurance Company, bind insurance coverage, waive or alter any provision of the insurance application or the Policy under which a certificate of insurance is issued. *No advertising material (on paper, over the radio or television or on the Internet) being the product's, HPA or the Insurance company's name or describing any named product administered by HPA can be produced without prior written approval from HPA and the insurance company.

Date: _____ Signature: _____  Title: _____

**Mail all completed forms including the commission addendums with copies of your current license(s) to
HPA or fax them to: 1-813-963-5570
HPA, Inc., 14497 N. Dale Mabry Hwy. Suite 200 Tampa FL 33618-2047**