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:

SECURITY LIFE APPOINTMENT REQUEST FORM

Agent Name ______________________ Date of Birth__________ Social Security Number ______________________

Corporation/Agency Name______________________________________ Tax I.D. ______________________

Business Street Address ______________________ City ____________ St.______ Zip ________County:__________

Resident Street Address______________________ City ____________ St. ______Zip________County:__________

Business Telephone (_______) ____________Fax # (________) ______________ Resident Telephone (________) ____________

E-mail Address______________________________ Web page Address ______________________________

UPS Delivery Address ______________________________ City______________ St.________ Zip __________

Are you interested in on-line sales …….. Yes ❑ No ❑ Email Address ______________________________

If Commissions are to be paid to an Agency or Corporation, and you are not the Owner? Officer, we need the Commissions Assignment Form signed by you. We must also have another Appointment Request Form completed by the Agency Owner / Officer; and copies of their license and the Agency's (if applicable).

Complete each of the following questions 1 through 16:

1. Lines of Insurance for which you are licensed _______ Life _______ Accident / Health _______ Other
2. Are you currently appointed with either Security Life or Congress Life? If yes, _______ Resident ; or _______Non-Resident
3. Did you submit an application for Insurance with this application for appointment? Yes ❑ No ❑
4. List the state(s) in which you are licensed and wish to be appointed: State ______________ License # ______________;
   State ______________ License # ______________; State ______________ License # ______________;
   State ______________ License # ______________; State ______________ License # ______________;
5. In the state(s) you are requesting for appointment. Do you hold a current appointment with another Insurance Company? If yes, please list below:
   Name ______________________ Address ______________________ Phone ______________
   Name ______________________ Address ______________________ Phone ______________
   Name ______________________ Address ______________________ Phone ______________
6. List the Non Resident license currently held: State ____________ License # ____________;
   State ____________ License # ____________; State ____________ License # ____________
7. How long have you lived at your present address? __________
8. List your resident address(s) from the past five (5) years (city and state only): City ______________ State ______________;
   City ______________ State ______________; City ______________ State ______________
9. List your FIVE YEAR EMPLOYMENT HISTORY; begin with your present employment. If self employed, describe what you do, and give address.
   Dates Name of Employer City Your Position Reason You Left

____

____

If "Yes" to any questions 9 through 16, enclose complete details on a separate piece of paper.

10. Have you ever had an application for an insurance license declined by any insurance department? Yes ❑ No ❑
11. Have you ever had an insurance license suspended or revoked by any insurance department or had a complaint issued against you by any insurance department? Yes ❑ No ❑
12. Is any charge by any state currently pending against you or against the agency or any member of the agency? Yes ❑ No ❑
13. Have you ever been charged with or convicted of a felony or of any crime involving moral turpitude? Yes ❑ No ❑
14. Are there any outstanding judgments or liens (including state or federal tax liens) against you? Yes ❑ No ❑
15. Has your appointment ever been terminated by an insurance company for reasons other than lack of production? Yes ❑ No ❑
16. Does any insurer, insured, or other person claim any indebtedness of you as a result of any insurance transactions or business? Yes ❑ No ❑

PLEASE READ CAREFULLY AND SIGN

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 which I am seeking appointment and that I am withholding no information which would effect my qualification for this appointment with Security Life Insurance Company of America.

By my signature below, I hereby release any individual or institution, including its officers, employees, or related personnel, both individually and collectively, from any and all liability for damages of whatever kind, which may at the time result to me, because of compliance with this authorization and request to release information or any attempt to comply with it. A copy of this authorization is as valid as the original.

Broker or Agent (signature):______________________________ Date:____________________

Mail or Fax all (3) completed pages and attachments to:
Attention: Kara Chastain , David Crotts & Associates, Inc.
422 Montague Ave. Suite 7, Greenwood, SC 29649-1961
Office: 800-803-7873 Fax: 864-229-7392

Health Plan Administrators
Independence Holding Group

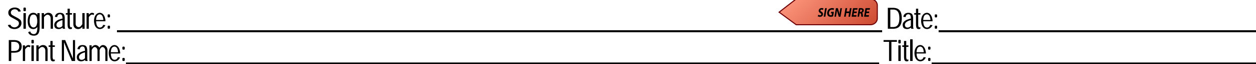
AGENT HPA STATEMENT OF UNDERSTANDING FORM:

David A. Crotts & Associates Inc.

AGENT 10% first year & 5% renewal years ~ NEW Competitor Smile Dental 10% first & renewal years ~ Competitor Award Group Dental

Health Plan Administrators, Inc. (herein called HPA), agrees to pay appointed agent Commissions equal Premiums due and paid to Security Life Insurance Company of America in accordance with and subject to the conditions and covenants below.

- The term "premiums due and paid" shall mean monies, excluding any administrative fees or charges, due and paid for the Security Life Dental Plan to HPA after the effective date of this Agreement by each insured and for whom the Agent is the Agent or broker of record.
- Commissions shall be payable only when Agent is (a) properly licensed to transact insurance business for the Security Life Insurance Company of America; and (b) is continuously recognized by the insurer as the agent or broker of record to receive said commissions.
- This Agreement may be terminated by either party with a 30 days written notice but only with respect to new cases. Such terminations will have no effect on the payment of commissions on business written prior to the effective date of termination as may otherwise be payable.
- No advertising material bearing HPA or the Insurance Company's name or describing or naming a product administered by HPA will be issued without prior written approval to HPA.
- The agent is an independent contractor, not an employee of HPA. 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. Representation and opinion of the Agent are not binding on the Insurance Company.

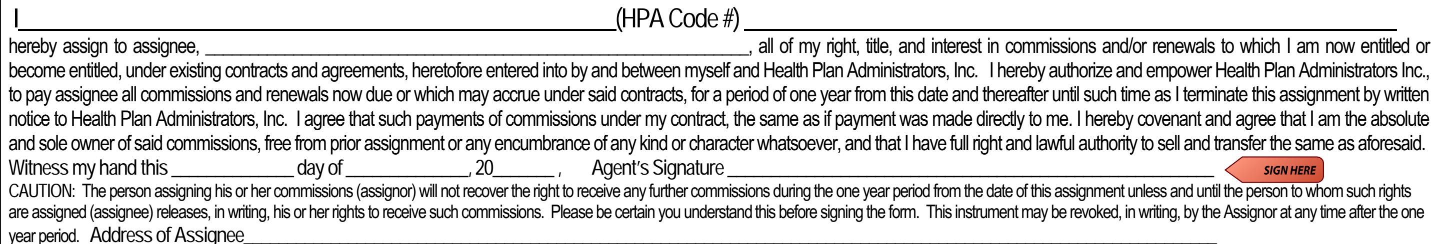

Signature: ______________________________ SIGN HERE Date: ______________
Print Name: ______________________________ Title: ______________

Agent Code #: ______________________________

GA Name: ______________________________ HPA Code # ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
Phone #: ______________ Fax #: ______________ Email: ______________
Address: ______________________________ City: ______________ ST: ________ Zip: ________
MGA Name: ______________________________ HPA Code # ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
Phone #: ______________ Fax #: ______________ Email: ______________
Address: ______________________________ City: ______________ ST: ________ Zip: ________

COMMISSION ASSIGNMENT FORM
(Only complete the following if you want HPA to pay your commissions to a Corporation, Agency or another Agent.)

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 ______________________________ SIGN HERE
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 ______________________________

Instructions:

1. You must complete all of the questions and sign the first page.
2. Read and sign the HPA Statement of Understanding form
3. **Sign the authorization for Security Life Ins. Co. of America to conduct a background check.**
4. **Attach current copies of your state's Health / Accident / Life Agent / Broker's license.**
5. **You MUST include your CHECK to PAY for your state appointment fee(s).**

Security Life requires that the appointment be approved before you solicit in the states of CO, GA, IL, IN, MO, MT, OR, RI, and WA.

Mail or Fax all (3) completed pages and attachments to:
Attention: Kara Chastain , David Crotts & Associates, Inc.
422 Montague Ave. Suite 7, Greenwood, SC 29649-1961
Office: 800-803-7873 Fax: 864-229-7392

FOR HOME OFFICE USE ONLY:

HPA, INC. RECOMMENDATION FOR APPOINTMENT

I have conducted a personal interview on the above named **agent** on (date) ______________, and find no reason he / she should not be appointed to represent Security Life Insurance Company of America.

____
Health Plan Administrators, Inc. Date

(HPA-SLICA Agent 7-08)

David A. Crotts
& Associates Inc.

NOTICE TO PROSPECTIVE AGENT / BROKER

Your application for appointment is being considered. In order to fully evaluate all factors that may effect your appointment status, a credit report may be obtained or prepared by the following credit bureau: PRSI (800) 232-0247
IF A CREDIT REPORT IS REQUESTED, YOU HAVE THE RIGHT TO RECEIVE A COPY OF YOUR CREDIT REPORT BY INDICATING YES OR NO BELOW. YOUR CREDIT REPORT WILL BE MAILED TO YOU.

I have read and understand the above notice. If a credit report is requested in connection with my appointment application, I want a free copy of my credit report: YES ❑ NO ❑

Name (signature):____ Date:____________________

RELEASE AUTHORIZATION AND
FAIR CREDIT REPORTING ACT DISCLOSURE

This is to notify you that in connection with your application for appointment/contract, we may procure a consumer report on you as part of the process of considering your application. In the event that information from the report is utilized in whole or in part in making an adverse decision, before making the adverse decision, we will provide you with a copy of the consumer report and a description in writing of your rights under the Fair Credit Reporting Act. Please be advised that we may also obtain an investigative consumer report including information as to your character, general reputation, personal characteristics, and mode of living. This information may be obtained by contacting your present and previous employers or references supplied by you. Please be advised that you have the right to request, in writing, within a reasonable time, that we make a complete and accurate disclosure of the nature and scope of the information requested.

By signing below, I hereby authorize all entities having information about me, including present and former employers, criminal justice agencies, departments of motor vehicles, schools, and credit reporting agencies, to release such information to Business Information Group and/or Security Life Insurance Company of America.

This release and authorization shall remain valid and in effect during the term of your appointment. We reserve the right to run subsequent consumer reports and/or investigative consumer reports on an as-needed basis.

____
Authorized Signature

__________ ______________________________________
Date of Authorized Signature

____
Date of Birth*

* - Date of Birth is required by law enforcement agencies and other entities for positive identification purposes when checking public records. It is confidential and will not be used for any other purposes.

Mail or Fax all (3) completed pages and attachments to:
Attention: Kara Chastain , David Crotts & Associates, Inc.
422 Montague Ave. Suite 7, Greenwood, SC 29649-1961
Office: 800-803-7873 Fax: 864-229-7392

A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT

The federal Fair Credit Reporting Act (FCRA) is designed to promote accuracy, fairness, and privacy of information in the files of every "consumer reporting agency" (CRA). Most CRA's are credit bureaus that gather and sell information about you - such as if you pay your bills on time or have filed bankruptcy - to creditors, employers, landlords, and other businesses. You can find the complete text of the FCRA, 15 U.S.C. 1681-1681u, at the Federal Trade Commission's web site (http://www.fic.gov). The FCRA gives you specific rights, as outlined below..You may have additional rights under state law. You may contact a state or local consumer protection agency or a state attorney general to learn those rights.

- You must be told if information in your file has been used against you. Anyone who uses information from a CRA to take action against you - such as denying an application for credit, insurance, or employment- must tell you, and give you the name, address, and phone number of the CRA that provided the consumer report.
- You can find out what is in your file. At your request, a CRA must give you the information in your file, and a list of everyone who has requested it recently. There is no charge for the report if a person has taken action against you because of information supplied by the CRA, if you request the report within 60 days of receiving notice of the action. You also are entitled to one free report every twelve months upon request if you certify that (l) you are unemployed and plan to seek employment within 60 days, (2) you are on welfare or (3) your report is inaccurate due to fraud. Otherwise, a CRA may charge you up to eight dollars.
- You can dispute inaccurate information with the CRA. If you tell a CRA that your file contains inaccurate information, the CRA must investigate the items (usually within 30 days) by presenting to its information source all relevant evidence you submit, unless your dispute is frivolous. The source must review your evidence and report its findings to the CRA. (The source also must advise national CRA's - to which it has provided the data - of any error.) The CRA must give you a written report of the investigation, and a copy of your report if the investigation results in any change, if the CRA's investigation does not resolve the dispute, you may add a brief statement to your file. The CRA must normally include summary of your statement in future reports. If an item is deleted or a dispute statement is filed, you may ask that anyone who has recently received your report be notified of the change.
- Inaccurate information must be corrected or deleted. A CRA must remove or correct inaccurate or unverified information from its files, usually within 30 days after you dispute it. However, the CRA is not required to remove accurate data from your file unless it is outdated (as described below) or cannot be verified, if your dispute results in any change to your report, the CRA cannot reinsert into your file a disputed item unless the information source verifies its accuracy and completeness. In addition, the CRA must give you a written notice telling you it has reinserted the item. The notice must include the name, address and phone number of the information source.
- You can dispute inaccurate items with the source of the information, if you tell anyone - such as a creditor who reports to a CRA - that you dispute an item, they may not then report the information to a CRA without including notice of your dispute. In addition, once you've notified the source of the error in writing it may not continue to report the information if it is, in fact, an error.
- Outdated information may not be reported. In most cases, a CRA may not report negative information that is more than seven years old; ten years for bankruptcies. Access to your files is limited. A CRA may provide information about you only to people with a need recognized by the FCRA -usually to consider an application with a creditor, insurer, employer, landlord, or other business.
- Your consent is required for reports that are provided to employers, or reports that contain medical information. A CRA may not give out information about you to your employer, or prospective employer, without your written consent. A CRA may not report medical information about you to creditors, insurers, or employers without your permission.
- You may choose to exclude your name from CRA lists for unsolicited credit and insurance offers. Creditors and insurers may use file information as the basis for sending you unsolicited offers of credit or insurance. Such offers must include a toll-free phone number for you to call if you want your name and address removed from future lists. If you call, you must be kept off the lists for two years. If you request, complete, and return the CRA form provided for this purpose, you must be taken off the lists indefinitely.
- You may seek damages from violators. If a CRA, a user or (in some cases) a provider of CRA data, violates the FCRA, you may sue them in state or federal court.

FOR QUESTIONS OR CONCERNS REGARDING :	PLEASE CONTACT:
• CRAs creditors and others not listed below:	• Federal Trade Commission, Consumer Response Center - FCRA Washington, DC 20580, Phone: 202-326-3761
• National banks, federal branches/agencies of foreign banks (word “National” or initials “N.A.” appear in or after bank’s name)	• Office of the Comptroller of the Currency Compliance Management, Mail Stop 6-6, Washington, DC 20219, Phone: 800-613-7643
• Federal Reserve System member banks (except national banks, and federal branches/agencies of foreign banks)	• Federal Reserve Board, Division of Consumer & Community Affairs, Washington, DC 20551, Phone: 202-452-3693
• Savings associations and federally chartered savings banks (word “Federal” or initials “F.S.B.” appear in federal institution’s name)	• Office of Thrift Supervision, Consumer Programs, Washington, DC 20552, Phone: 800-842-6929
• Federal credit unions (words “Federal Credit Union” appear in institution’s name)	• National Credit Union Administration, 1775 Duke Street Alexandria, VA 22314, Phone: 703-518-6360
• State chartered banks that are not members of the Federal Reserve System	• Federal Deposit Insurance Corporation, Division of Compliance & Consumer Affairs Washington, DC 20429, Phone: 800-934-FDIC
• Air, surface, or rail common carriers regulated by former Civil Aeronautics Board or Interstate Commerce Commission	• Department of Transportation, Office of Financial Management Washington, DC 20590, Phone: 202-366-1306
• Activities subject to the Packers and Stockyards Act, 1921	• Department of Agriculture, Office of Deputy Administrator - GIPSA Washington, DC 20250, Phone: 202-720-7051

Producer Appointment Credit Card Payment Form
Security Life Insurance Company
PLEASE USE A SEPARATE FORM FOR EACH AGENT OR AGENCY BEING APPOINTED

1. **Circle the states to indicate in which you wish to be appointed. (resident or non-resident)***

   ***Note that some states charge different fees for agent or agency.**

2. **Complete and sign the form below to pay appointment fees by credit card.**

Agency Name (if an agency is being appointed)		Agency Resident State
Producer's Last Name (If producer is being appointed)	Producer's First Name	Producer's Resident State

CARDHOLDERS INFORMATION (Please Print)

Last Name	First Name	
Street Address	State	Postal Code
Email Address	Telephone Number	Fax Number

AUTHORIZATION AGREEMENT: **(When paying Credit Card please complete the section below)**

As a convenience to me, I authorize Security Life Insurance Company of America to initiate entries to my bank credit card account for my state appointment fee(s). I understand this will occur as soon as my appointment is approved and that such record will appear on my monthly statement. I agree that if any such charge be dishonored, whether with or without cause and whether intentionally or inadvertently, the bank or credit card company shall be under no liability whatsoever.

Master Card Visa

SIGN HERE

______________________________, __________, ______________________________
Credit Card Holder's Name Date Credit Card Holder's Signature

Credit Card # ____ Expiration Date ______/____/_____

Credit Card payment will be processed after the appointment(s) are approved by the state(s)

STATE	RESIDENT	NON-RESIDENT	STATE	RESIDENT	NON-RESIDENT	STATE	RESIDENT	NON-RESIDENT
AL	$30.00	$30.00	KS	$5.00	$5.00	NM	$23.00	$23.00
AL	No fee	No fee	KY	$40-AGT $100-AGCY	$50-AGT $120-AGCY	OH	$20.00	$20.00
AZ	No fee	No fee	LA	$20.00	$20.00	OK	$40.00	$40.00
AR	No fee	No fee	ME	No fee	No fee	OR	No fee	No fee
CA	$24.00	$24.00	MD-NA	No fee	No fee	PA	$15.00	$15.00
CO	No fee	No fee	MA-NA	$75.00	$75.00	RI-NA	No fee	No fee
CT-NA	No fee	No fee	MI	$5.00	$5.00	SC	No fee	No fee
D.C.	$25.00	$25.00	MN	$10.00	$10.00	SD	$10.00	$20.00
DE	$25.00	$25.00	MS	$10.00	$10.00	TN	$15.00	$15.00
FL-NA	$60.00	$60.00	MO	No fee	No fee	TX	$10.00	$10.00
GA	$20.00	$20.00	MT	No fee	No fee	UT	No fee	No fee
HI	No fee	No fee	NC	$20.00	$20.00	VT-NA	$10.00	$10.00
ID	No fee	No fee	ND	$10.00	$10.00	VA	$14.00	$14.00
IL	No fee	No fee	NE	$8.00	$8.00	WA	$20.00	$20.00
IN	No fee	No fee	NV	$15.00	$15.00	WV	$25.00	$25.00
IA	$10.00	$10.00	NH-NA	$25.00	$25.00	WI	$7.00	$24.00
			NJ-NA	No fee	No fee	WY	$15.00	$15.00

NA = Smile Dental & Award Group Dental are not available