

Revised 5.22.08



FAX 972.915.3288

or

E-mail to contracting@ahcp-ausa.com

GOLDEN RULE

UnitedHealthcare®

Underwritten By Golden Rule

CONTRACTING AND APPOINTMENT PAPERWORK

Print Agents Name

Agents Contract Level

E-mail address

Phone number

Print Direct Uplines Manager/Agent name

FAX TO 972.915.3288 or E-mail a scanned copy to
contracting@ahcp-ausa.com

GRIC Manager/Representative CHERYL PICKETT
 Independent Broker Financial Services Company Name: F3A02 - AHCP

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 AHCP, 020690863
 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/ Blue Shield	<input type="checkbox"/> Golden Rule	<input type="checkbox"/> Pacific Care
<input type="checkbox"/> American Community	<input type="checkbox"/> Celtic	<input type="checkbox"/> Humana	<input type="checkbox"/> Unicare
<input type="checkbox"/> American Medical Security	<input type="checkbox"/> Fortis/Time/Assurant	<input type="checkbox"/> John Alden	<input type="checkbox"/> None
<input type="checkbox"/> American Republic		<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 _____

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.

Printed Name

Social Security Number

Signature

Date

Home Address

City, State, and ZIP

Golden Rule[®]

A UnitedHealthcare Company

Sign and Return this Page to Golden Rule

**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-0405), consisting of this page and four (4) other pages, as well as the Rules and Regulations (Rules-0405), 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)*.

YOU:

Print or type *Your Name*

By:

Print Name (and title if signing in a representative capacity)

X

Signature

X

Date

BENEFICIARY DESIGNATIONS (See 3.9):	Name	Address	Relationship
Primary Beneficiary(ies):			
<hr/>			
Contingent Beneficiary(ies):			
<hr/>			
<hr/>			
<hr/>			

Producer Information

=====

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

BY:

X

Signature

Date

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

IBC-0405

ASSIGNMENT OF COMMISSIONS AND OTHER COMPENSATION

To: 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 affiliated company (collectively, "the Company").

If and when the Company owes me compensation because I have sold or secured the sale of insurance products of the Company or for any other reason, I (the undersigned "Assignor") do not wish to receive that compensation, but instead assign all of the compensation to, and direct the Company to pay all of it to, the person or entity I have written below as Assignee:

<u>AHCP</u>		<u>020690863</u>		
Assignee Name (person/entity to be paid)		Social Security/tax ID Number		
<hr/>				
Street	City	State	ZIP	Phone

This Assignment applies to (select ONE):

- all first year and renewal compensation; or
- all compensation attributable to my business written *after* the date this form is processed by the Company (unless for compensation attributable to my business written prior to the date this form is processed by the Company for which my Assignee has received advances on the compensation related to such business, in which case the assignment applies to all business written after the effective date of the Commission Advance Agreement (the "Advance Agreement") between the Company and my Assignee).

I understand and agree that:

1. Payments made by the Company pursuant to this Assignment fully discharge all of the Company's financial obligations to me under any compensation arrangement between us (individually or collectively the "Contract").
2. This Assignment is subject to, and does not affect, any terms or conditions of the Contract except as specifically provided herein.
3. This Assignment is subject to applicable state and federal laws regarding assignment of commissions by insurance producers (by whatever name called). The Company will not be bound by this Assignment in any instance in which it believes applicable law prevents it from paying the Assignee, and it then may pay the person or entity that it, in its sole discretion, determines to be appropriate under the circumstances.
4. This Assignment shall remain in effect, and is binding on both myself and the Company, until revoked. I may revoke this Assignment by sending written notice to the Company. Such revocation will only apply to business written after the effective date of the revocation, and this Assignment will remain in effect for business written for the Company prior to that date. Revocation will be effective on the latter of the date I request, or thirty (30) days after the Company's receipt of the notice.
5. This Assignment does not apply to merchandise, trips or other non-cash incentives, awards, contests or other remuneration (collectively "prizes") that the Company may offer from time to time. It also does not apply to a cash equivalent in the event either I or the Company choose to remit or accept such cash equivalent in lieu any particular prize.
6. Assignor understands the Assignee may enter into an Advance Agreement with the Company. The Advance Agreement entitles the Assignee to receive an advance on the payment of compensation for business issued by Company after the effective date of the Advance Agreement. Assignor understands and acknowledges that the Company, as a condition to agreeing to the Advance Agreement, requires the Assignee obtain an assignment of commissions from all sub-brokers, including Assignor.

Assignor Signature

Assignor Printed Name

Date Signed

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, if different from above	
Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ <input type="checkbox"/> Exempt payee <input type="checkbox"/> 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 Line 1 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
or
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.

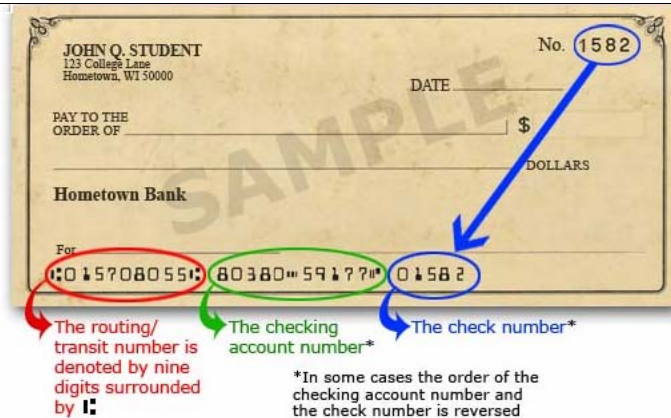
The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

Authorization for Automatic Deposit

I (We) Hereby authorize AHCP to initiate direct deposit of commissions and, if necessary, make corrections for any entries made to my account in error.

Agent or Agency Name	
Social Security Number or Tax ID Number	
Phone Number	Email Address
Please indicate transaction type: <input type="checkbox"/> Set-Up <input type="checkbox"/> Change <input type="checkbox"/> Cancel	
Please indicate type of account: <input type="checkbox"/> Checking <input type="checkbox"/> Savings	
Name of Financial Institution:	
Bank—City, State, Phone Number:	
Routing Number:	
Account Number:	



If you don't have paper checks, contact your bank to obtain your bank routing number and account number information

Agent Signature _____ Date _____

PLEASE INCLUDE A COPY OF A VOIDED CHECK

