

Appointment Application Checklist

Please review all of the items listed below to ensure that all required appointment documents are submitted.

**** IMPORTANT NOTE ****

Although all fields are important, all shaded areas are required fields on the first two pages of the application, and will cause a delay in your application being processed. Your application will not be processed without that information completed.

- Prospective Broker Application:** Complete, Sign and Date
Entire form must be completed.

- Profile Information:** Complete

- Fair Act Reporting Disclosure:** Complete, Sign and Date

- Assignment of Commission:** Sign, and Date
NOTE: Applies if commissions are paid to an key agency or key broker.
NOTE: Make sure one of the two boxes on this form is marked.

- Explanation Page:** Complete if any legal questions (1-9) on the Prospective Broker Application is answered "YES"
NOTE: If yes to question 8, submit proof of two most recent payments in addition to explanation.
 - *IRS Tax Lien - Submit proof of two most recent payments OR resolution/settlement letter from the IRS.**NOTE: If yes to question 9, submit copy of discharge papers or proof of most recent payment.*

- Independent Broker Contract Signature Page:** Sign and Date

- Resident State License**
Include non-resident licenses if requesting non-resident appointments.

- Credit Card Authorization form:** Complete
 - VISA or MasterCard accepted
 - Include credit card expiration date

Email or fax completed appointment applications to:

- ▶ Email: kblicensing@goldenrule.com
- ▶ Fax: 317-715-7375

*Please allow approximately 5-7 working days for your appointment request to be processed.

NOTE: The *SUB-BROKER CONTRACT CHANGE REQUEST/ASSIGNMENT FORM* should only be completed when a producer is currently active with Golden Rule.



A UnitedHealthcare Company

PROSPECTIVE BROKER APPLICATION

GRIC Manager/Representative Cheryl Pickett Email to: kblicensing@goldenrule.com

Independent Broker Financial Services Company Name F1G72 - HOMETOWN BENEFITS

Complete Name I prefer to be called:

Name of Agency or Company

Business Street Address

(Required for Supplies - No PO Box address)

Business Mailing Address

City County State ZIP

Business Phone Fax E-mail

Home Address

City County State ZIP

Home 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 HOMETOWN BENEFITS, 262316973
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.)

- 1. Have you ever had an appointment terminated by any insurance company or financial services institution (for reasons other than production)?
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?
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?
4. Has any state or federal self-regulatory body of any type (such as National Assn. of Securities Dealers) ever taken any disciplinary measures against you?
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?
6. Have you ever been the subject of any civil or administrative proceeding, including one initiated by a state department of insurance?
7. Do you have any felony charges pending against you, or have you ever pled guilty or nolo contendere to or been convicted of a felony or a crime involving moral turpitude?
8. Do you have any unsatisfied liens (tax or otherwise) or judgments (civil or otherwise) against you?
9. Have you been the subject of a bankruptcy petition or proceeding in the past seven (7) years?

(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 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 requirements have been met, and you have been advised that fact in writing by the Company.

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 an 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, criminal and civil history, and/or mode of living. I understand that the Company will use this information in whole or in part as a 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 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

PROFILE INFORMATION

1. Over the past 12 months, what percentage of total revenue from your current insurance business does individual health represent? (Check one.)

- 0%-10% 11%-24 25%-49% 50% or more

2. What type of insurance is your primary line of business? (Check one.)

- | | | |
|--|--|--------------------------------|
| <input type="checkbox"/> Annuities/LTC | <input type="checkbox"/> Life | <input type="checkbox"/> Other |
| <input type="checkbox"/> Disability Income Insurance | <input type="checkbox"/> Medicare Business
(Part D, Supplement, etc.) | |
| <input type="checkbox"/> Financial Services | <input type="checkbox"/> Property/Casualty | |
| <input type="checkbox"/> Group Health | <input type="checkbox"/> Supplemental Policies
(Accident, Dental, Vision) | |
| <input type="checkbox"/> Individual Health | | |

3. How many new individual health applications did you personally write in the past 12 months with all carriers combined—excluding Short Term, Medicare Plans, Employer, and Employer/Group policies? (Check One.)

- | | |
|-------------------------------|----------------------------------|
| <input type="checkbox"/> 0 | <input type="checkbox"/> 21-50 |
| <input type="checkbox"/> 1-5 | <input type="checkbox"/> 51-100 |
| <input type="checkbox"/> 6-10 | <input type="checkbox"/> 101-200 |
| <input type="checkbox"/> 11-2 | <input type="checkbox"/> 201+ |

4. How many do you plan to write over the next 12 months? (Check one.)

- More
 Same
 Less

5. Which of the following carriers do you consider to be the primary and secondary recipients of your new individual health applications? Please mark your primary carrier with the number 1, and your secondary carrier with the number 2. Please mark 1 and 2 ONLY.

- | | | |
|---|---|---------------------|
| ___ Aetna | ___ Cigna | ___ Medical Mutual |
| ___ American Community | ___ Coventry/Health America | ___ PacifiCare |
| ___ American Medical Security | ___ Golden Rule/UnitedHealth One/UnitedHealthcare | ___ World Insurance |
| ___ Assurant/Fortis/Time | ___ Health Net | ___ Unicare |
| ___ Blue Cross Blue Shield/
Anthem/Wellpoint | ___ Humana One | ___ None |
| ___ Celtic | ___ Kaiser Permanente | ___ Other _____ |
| | ___ Mega Life and Health | |

6. Over the past 12 months, how many of the following products have you personally written?

Short Term Medical Plans

- 0
- 1-9
- 10-24
- 25+

Medicare Plans (Supplements,
Advantage Plans or Part D)

- 0
- 1-9
- 10-24
- 25+

Health Savings Accounts (HSAs)

- 0
- 1-9
- 10-24
- 25+

Dental (standalone) Insurance Plans

- 0
- 1-9
- 10-24
- 25+

Accident (standalone) Insurance Plans

- 0
- 1-9
- 10-24
- 25+

Critical Illness (standalone) Insurance Plans

- 0
- 1-9
- 10-24
- 25+

7. How many states are you licensed in for health insurance?

- 1
- 2-4
- 5-9
- 10 or more

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:

PLEASE PRINT HOMETOWN BENEFITS GROUP 262316973
Assignee Name (person/entity to be paid) Social Security/Tax ID Number

PLEASE PRINT 2101 W CHESTERFIELD STE B202 SPRINGFIELD MO 65807-6985
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

Date Signed

Assignor Printed Name

Social Security/Tax ID Number

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-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)*.

YOU:

Print or type *Your Name*

By:

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

X

Signature

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. _____

IBC-0410

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:

X
Printed Name (Please print legibly)

Telephone Number *Required*

X
Signature of Cardholder

Payment is for: Appointment Fee
(Please check one) Renewal Fee
 Charge Back

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

State Resident and Nonresident Appointment Fees

If payment is for appointment fee(s), please indicate the state and fee(s) 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/Agency \$25	<input type="checkbox"/> \$25/Agency \$25
California	<input type="checkbox"/> \$23/Agency \$23	<input type="checkbox"/> \$23/Agency \$23	New Jersey	<input type="checkbox"/> \$25/Agency \$25	<input type="checkbox"/> \$25/Agency \$25
Colorado	<input type="checkbox"/> N/A	<input type="checkbox"/> N/A	New Mexico	<input type="checkbox"/> \$20	<input type="checkbox"/> \$20
Connecticut	<input type="checkbox"/> No Fee	<input type="checkbox"/> No Fee	Nevada	<input type="checkbox"/> \$15/Agency \$15	<input type="checkbox"/> \$15/Agency \$15
Delaware	<input type="checkbox"/> \$25	<input type="checkbox"/> \$25	North Carolina	<input type="checkbox"/> \$20	<input type="checkbox"/> \$20
District of Columbia	<input type="checkbox"/> \$25/Agency \$25	<input type="checkbox"/> \$25/Agency \$25	North Dakota	<input type="checkbox"/> \$10/Agency \$10	<input type="checkbox"/> \$10/Agency \$10
Florida	<input type="checkbox"/> \$60	<input type="checkbox"/> \$60**	Ohio	<input type="checkbox"/> \$20/Agency \$20	<input type="checkbox"/> \$20/Agency \$20
Georgia	<input type="checkbox"/> \$10	<input type="checkbox"/> \$10	Oklahoma	<input type="checkbox"/> \$55/Agency \$55	<input type="checkbox"/> \$55/Agency \$55
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/Agency \$15	<input type="checkbox"/> \$15/Agency \$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/Agency \$10	<input type="checkbox"/> \$20/Agency \$20
Kansas	<input type="checkbox"/> \$5/Agency \$5	<input type="checkbox"/> \$5/Agency \$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/Agency \$10	<input type="checkbox"/> \$10/Agency \$10
Louisiana	<input type="checkbox"/> \$20/Agency \$20	<input type="checkbox"/> \$20/Agency \$20	Utah	<input type="checkbox"/> No Fee	<input type="checkbox"/> No Fee
Maine	<input type="checkbox"/> \$30/Agency \$30	<input type="checkbox"/> \$70/Agency \$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"/> \$12/Agency \$12	<input type="checkbox"/> \$12/Agency \$12
Massachusetts	<input type="checkbox"/> \$75/Agency \$75	<input type="checkbox"/> \$75/Agency \$75	Washington	<input type="checkbox"/> \$20/Agency \$20	<input type="checkbox"/> \$20/Agency \$20
Michigan	<input type="checkbox"/> \$5/Agency \$5	<input type="checkbox"/> \$5/Agency \$5	West Virginia	<input type="checkbox"/> \$25	<input type="checkbox"/> \$25
Minnesota	<input type="checkbox"/> \$10	<input type="checkbox"/> \$10	Wisconsin	<input type="checkbox"/> \$16	<input type="checkbox"/> \$50
Mississippi	<input type="checkbox"/> \$25	<input type="checkbox"/> \$25	Wyoming	<input type="checkbox"/> \$15/Agency \$15	<input type="checkbox"/> \$15/Agency \$15

* Fee paid by appointing insurance company.

** Add \$6 per Florida county.

SUB-BROKER CONTRACT CHANGE REQUEST/ASSIGNMENT FORM

Subject to acceptance by UnitedHealthOne, or any of its affiliates, please change my existing contract with UnitedHealthOne to show I am a sub-broker under the Key Broker contract between **HOMETOWN BENEFITS GROUP** and UnitedHealthOne.

Key Broker

- Pay Commissions directly to me, and the override to the Key Broker.
- Pay Commissions to agency tax id # _____ and the override to the Key Broker.
- Pay Commissions directly to the Key Broker.

Agreed and accepted:

Must be completed by the Sub-Broker

Sub-Broker: _____		
<input checked="" type="checkbox"/> Sub-Broker Signature		
Printed Name		
Producer Number		
Date		
Address		
City	St	Zip

Must be completed by the Key Broker/Principal

Key Broker: HOMETOWN BENEFITS GROUP	
By: _____	
<input checked="" type="checkbox"/> Authorized Signatory of Agency	
Printed Name	
262316973	F1G72
Tax ID Number	Agency Code
Date	
2101 W CHESTERFIELD STE B202	
Address	
SPRINGFIELD MO 65807-6985	
City	St Zip
Do you authorize this Sub-Broker to be advanced?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Accepted by UnitedHealthOne:

Key Broker Account Manager

Date

Effective Date: _____

Brokers that have written 3 or more individual health applications with UnitedHealthOne in the last 6 months are not eligible to transfer.

Brokers who are appointed under a Key Broker must have 0 production in the past 6 months or must obtain a written release from their current Key Broker

GOLDEN RULE USE ONLY			
KB Status	KB # of Subs	KB # of Subs Allowed	KB Past 12mth Prod
Broker past 6mth Prod	Current Agency Code	Release Required Y/N	