



**UnitedHealthOne/Golden Rule
New Agent -- Appointment Paperwork**

Please follow the instructions below for a new agent appointment with UnitedHealthOne/Golden Rule under GoHealth. Please review and complete the forms carefully. Incomplete or illegible forms will be returned. New appointments generally take two weeks for processing.

All forms can be scanned and sent to agencyervices@gohealth.com or faxed to 312-948-2621. Please make sure that the Agent's commission level (the code, not the percentage) is indicated in the e-mail or fax cover sheet.

Check	Form	Instructions
	Prospective Broker Application	<p>Must say "F3H39-GoHealth LLC" in the top right corner. Do not change edit.</p> <p>Please write legibly and provide all requested information.</p> <p>In the middle of the page, it designates that all commissions be paid to GoHealth. Do not edit.</p> <p>Answer Questions 1 through 9. Provide a detailed explanation to any YES answer on the PBA Explanation Page. If YES to Question 8, Agent must provide proof of payments or a repayment schedule. If YES to Question 9, Agent must provide a copy of discharge of Bankruptcy or repayment schedule.</p>
	Agent Profile	Agent should use "best efforts" to answer each question.
	Fair Credit Reporting Act Disclosure & Authorization	Sign and provide Social Security Number and contact information.
	Assignment of Commissions	All commissions/compensation for new business MUST be assigned to GoHealth. Do not change or edit the form. Agent must sign as "Assignor" at the bottom of the page and provide Social Security Number.
	Independent Broker's Contract Signature Page	Please sign and indicate beneficiary designation.
	Appointment Fee/Credit Card Authorization Form & Health Insurance License(s)	Please provide credit card information and check of the box next to each state where the Agent is seeking appointment. Include a copy of the Agent's health insurance license for each state.

PROSPECTIVE BROKER APPLICATION

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

KEY BROKER: **GOHEALTH – AA1075586**

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 _____ *(email address required if registering on estore)*

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 GOHEALTH, 263235175
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 Assn. 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 nolo contendere 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 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.

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"/> 11-20 | <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

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

FCRA-0306

ASSIGNMENT OF COMMISSIONS AND OTHER MONETARY 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 it to, and direct the Company to pay it to, the person or entity I have written below as Assignee per my applicability instructions below:

<u>GOHEALTH</u>	<u>263235175</u>		
Assignee Name (person/entity to be paid)	Social Security/tax ID Number		
<u>214 W HURON ST</u>	<u>CHICAGO</u>	<u>IL</u>	<u>60654</u>
Street	City	State	ZIP Phone

This Assignment applies to (select and complete option 1 OR 2 below):

1. **All monetary compensation including commissions, monetary bonuses, monetary incentives/prizes.**
(in addition, check one box below)
- all monetary compensation attributable to my business written **after** the date this form is processed by the Company
- OR
- all monetary compensation for all business issued, including any business issued prior to this date (only allowed if no prior Assignment has been submitted by the Assignor to the Company)
2. **Commissions only (monetary bonuses and monetary incentives/prizes will be paid directly to you)**
(in addition, check one box below)
- all commissions attributable to my business written **after** the date this form is processed by the Company
- OR
- all first year and renewal commissions for all business issued, including any business issued prior to this date (only allowed if no prior Assignment has been submitted by the Assignor to the Company)

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.
2. This Assignment is subject to, and does not affect, any terms or conditions of any such compensation arrangements 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 later of the date I request, or not later than thirty (30) days after the Company's receipt of the notice.
5. This Assignment does not apply to non-monetary incentives/prizes (e.g. merchandise, trips, non-cash incentives, awards, contest results, or any other non-cash remuneration).
6. Assignor understands the Assignee may enter into a Commission Advance Agreement ("Advance Agreement") with the Company. The Advance Agreement entitles the Assignee to receive an advance on the payment of compensation for business issued by the 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 to obtain Assignments from all sub-brokers, including the Assignor. Assignor further agrees that commissions attributable to any business written by the Assignor that are advanced to the Assignee under their Advance Agreement are hereby assigned to the Assignor, even if the business was written prior to the date of this Assignment.

Assignor Signature

Date Signed

Assignor Printed Name
37835-G-0311

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

