Hierarchy Form

Agent Name _____

GA Name _____

MGA Name _____

SGA Name _____

FMO Name _____

Please check ONE

Agent assigns commissions to an agency

Agent paid directly by HealthSpring

Agent Signature_____

Date_____

Contact information

All information is required to complete contracting

☐ Please Check if you will be conducting Telephonic Enrollments

Last Name, first name, middle initial | Date of Birth | Social Security Number

Address | City | State | Zip Code

Business Phone | Cell Phone | Fax Number | E-mail Address

Please list all websites and/or website affiliations:

Provider business office locations for last five years:

Ex: 10/12

Business address | City | State | ZIP Code | From | To

Business address | City | State | ZIP Code | From | To

Business address | City | State | ZIP Code | From | To

Professional designation:

Ex: 10/12

Type of professional designation | From | To

Type of professional designation | From | To

Type of professional designation | From | To

List any insurance agency affiliations for the past five years:

Name of agency | City where agency is located | From | To

Name of agency | City where agency is located | From | To

Please indicate the service area(s) in which you plan to sell HealthSpring (please select all that apply):

*(You **MUST** have a currently active state Health license in all of the states for the service areas you selected below)*

☐ Alabama	☐ Delaware	☐ Indiana	☐ N. Carolina
☐ Arizona	☐ Florida	☐ Kansas	☐ Pennsylvania
☐ Arkansas	☐ Georgia	☐ Maryland	☐ S. Carolina
☐ D.C.	☐ Illinois	☐ Mississippi	☐ Tennessee
		☐ Missouri	☐ Texas

Additional information:

If an answer to any of the following questions is "yes," attach details on separate sheet of paper.

	Yes	No
A. Has your license to sell insurance or HMO Products ever been denied, suspended or revoked by any state?	☐	☐
B. Have any complaints been filed against you with the State Department of Insurance or any other insurance regulatory board or agency within the last five years?	☐	☐
C. Have you ever been denied appointment or renewal appointment by any insurance and/or managed care company?	☐	☐
D. Have you ever been party to a lawsuit relating to the insurance or managed care industry?	☐	☐
1. Have any settlements ever been made on your behalf?	☐	☐
2. Are there any claims or cases presently filed or pending against you?	☐	☐
E. Have you ever filed for bankruptcy?	☐	☐
F. Have you ever been convicted or are you currently being charged or under investigation for any violation of the law other than minor traffic violations?	☐	☐
G. Are any legal actions pending against you by any employer, client, former associate, partner, state board of insurance, law enforcement agency or professional group or organization?	☐	☐

H. How long have you sold individual and/or group HMO products?

I. How long have you been in the insurance business?

J. Do you speak any foreign language?
If yes, indicate language(s):

I certify that the above statements are true and complete and no misrepresentations are contained with the application or attachments.

Signature _____ Date _____

Active appointments with insurance and/or managed care companies:

Company Name	From	**To**
Company Name	From	To
Company Name	From	To
Company Name	From	To

Authorization and release:

I understand that Cigna-HealthSpring Inc. will verify that the information in this application is correct and I hereby authorize Cigna-HealthSpring Inc. or its representatives to contact and obtain information references in this application from an individual present or former client, insurer, corporation or other business entity, regulatory or licensing agency, or state, city or federal agency.

By applying for appointment with Cigna-HealthSpring Inc., I extend absolute immunity to, and release and hold harmless from any and all liability: (i) Cigna-HealthSpring Inc., its representatives, employees, trustees, directors, and officers; (ii) any individual, present or former client, insurer, corporation, or other business entity, regulatory or licensing agency, or state, city or federal agency providing information, their representatives, employees, trustees, directors and officers; (iii) any third party for any acts, communications, reports, records, statements, documents, recommendations or disclosures involving me, requested or received by Cigna-HealthSpring Inc. and its representatives to, from, or by any third party, including otherwise privileged or confidential information.

I certify that the above statements are true and complete and no misrepresentations are contained within the application or attachments.

Name (please print) Signature Date

Application for appointment includes:

Completed application, with signature on authorization and release above
Copy of Current State License(s)

Return completed application along with required documents to:

Corporate Contracting
Contracting.mailbox@healthspring.com
Attn: Corporate Sales Operations
500 Great Circle Rd
Nashville TN 37228

Individual Leads

Cigna-HealthSpring is not responsible for supporting the Subordinate Broker or Agent with leads or financial support in their prospecting efforts. During a visit with the prospect, the Subordinate Broker or Agent can present the Cigna-HealthSpring Medicare Advantage products with full disclosure and enroll the prospect. Referrals may only be sought in accordance with Cigna-HealthSpring policy and CMS guidelines. Subordinate Broker or Agent must follow all guidelines and regulations that govern the proper procedure for prospecting, and selling, the Cigna-HealthSpring product including all requirements set forth under MIPPA and the CMS Medicare Marketing Guidelines.

Commissions – Individual Sales

Enrollments must be a result of the direct contact between the Subordinate, Broker or Agent and the individual prospect. Cigna-HealthSpring will pay a commission for each individual whom Subordinate, Broker or Agent enroll in a Cigna-HealthSpring Medicare Advantage/Prescription Drug Plan. Commissions are paid per the current commission schedule set forth in Exhibit A. The allocated portion of the commission payments will be paid directly to the Agent of Record during the normal commission payment schedule as set forth by Cigna- HealthSpring policy unless otherwise agreed between the parties.

By: _____

Print Name: _____

Date:_____

Cigna-HealthSpring
Assignment of Commissions

To _____Tax ID_____
(Legal entity that Commissions are being assigned to, hereinafter the "Assignee")

Assignee's Address_____

City_____State_____Zip Code_____

Telephone _____

For valuable consideration, the undersigned, herein called the Assignor, hereby assigns to the Assignee all of the Assignor's right, title, interest, claim or demand in and to any and all compensation now due and payable, or which may become due and payable, under existing contracts and agreements heretofore entered into by and between Cigna-HealthSpring, Inc. (the "Company") and Assignor.

Assignor hereby authorizes and empowers the Company to pay Assignee all compensation (including but not limited to over-riding commissions) now due or which may become due under the Agreement until such time as Assignor terminates this assignment by written notice to the Company. In the event of a termination of this Agreement, all changes will be applied on a prospective basis. Assignor acknowledges and agrees that such payment of compensation to Assignee shall constitute payment of such compensation to the Assignor as if paid directly to the Assignor and the Company shall be fully released from any and all responsibility to the Assignor for such payments. Assignor hereby acknowledges and agrees that assignment of compensation payable under the agreement does not release or otherwise relieve Assignor of any obligation or responsibility under the Agreement including, but not limited to, the obligation to pay commissions to any applicable "downline" sales hierarchy and/or the obligation to reimburse the Company for compensation paid on premiums subsequently refunded.

Assignor hereby covenants and agrees that Assignor is the absolute and sole owner of said compensation, free from assignment or encumbrance of any kind or character whatsoever, and has full right and lawful authority to so assign same. The Assignor shall at all times defend, indemnify and hold harmless the Company and its officers, agents, and employees from and against any and all suits, actions, losses, damages, claims, expenses (including but not limited to the Company's legal expenses) and liability of any character, type or description arising out of the execution or performance

of this assignment.

Assignor Signature _____Dated _____

Assignor Name _____
(Print)

Assignee Signature_____Dated _____

The Company acknowledges receipt of, and consents to the foregoing assignment, but assumes no responsibility for the validity or sufficiency hereof. This assignment is effective on the date signed by an authorized representative of the company.

By _____Dated _____
(Authorized Company Signature)

Company Representative Name _____Title _____
(Print)

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

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.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____

Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

6 City, state, and ZIP code

7 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 generally 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 instructions for line 1 and 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); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

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 3.

Sign Here	**Signature of U.S. person** ▶	**Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

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, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

Direct Deposit Authorization Form

Connecticut General Life Insurance Company
Cigna Health and Life Insurance Company
Direct Deposit Unit, C3DDS
900 Cottage Grove Road
Hartford, CT 06152
800.903.7711

Please read the instructions on the reverse side prior to completing this form.

PRODUCER NAME (Legal Entity)	TAX IDENTIFICATION NUMBER	PRODUCER CODE
PRODUCER'S BILLING ADDRESS *(Street, City, State, Zip Code)*		
PRODUCER'S EMAIL ADDRESS		
CONTACT NAME		TELEPHONE

PLEASE INCLUDE A VOIDED CHECK OR SPECIFICATION SHEET AS REQUESTED IN THE INSTRUCTIONS ON THE REVERSE SIDE OF THIS FORM. YOUR APPLICATION CANNOT BE PROCESSED WITHOUT THIS INFORMATION.

NOTE: A DEPOSIT TICKET IS NOT ACCEPTABLE.

Please Check One:

◯ Cancellation ◯ Enrollment ◯ Change

BANK ACCOUNT

BANK ACCOUNT NUMBER	BANK ROUTING NUMBER ☐☐☐☐☐☐☐☐☐
BANK ACCOUNT NAME	

LISTED NUMBER REFERS TO: ***(Please Check One)***

◯ Business Checking Account ◯ Business Savings Account ◯ Other (personal acct., etc.)

BANK NAME

BANK ADDRESS *(Street, City, State, Zip Code)*

Authorization is hereby granted to Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, HealthSpring Health and Life Insurance Company and their affiliates (collectively, "Cigna") to credit said account at the financial institution named above for the purpose of making commission payments. These Cigna companies are also granted authorization to correct inadvertent duplicate payment information. This authorization is to remain in effect until written notification is given to the application Cigna company in writing (at least ten (10) days in advance of any change) on a Direct Deposit Authorization Form.

AUTHORIZED SIGNATURE
Please note that this form must be printed and signed with a "wet" signature for it to be valid

PRINTED NAME AND TITLE	DATE

RELEASE AUTHORIZATION AND
FAIR CREDIT REPORTING ACT DISCLOSURE

The applicant for contracting acknowledges that this company may now, or at any time while contracted, verify information within the contract. 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 to you a copy of the consumer report and a description in writing of your rights under the Fair Credit Reporting Act,15 U.S.C. § 1681 et seq.

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 investigation requested.

Additional information concerning the Fair Credit Reporting Act, 15 U.S.C. § 1681 et seq., is available at the Federal Trade Commission's web site (http://www.ftc.gov).

By signing below, I hereby authorize all entities having information about me, including present and former employers, personal references, criminal justice agencies, departments of motor vehicles, schools, licensing agencies, and credit reporting agencies, to release such information to the company or any of its affiliates or carriers. I acknowledge and agree that this Release and Authorization shall remain valid and in effect during the term of my contract.

***For California*, Minnesota, and Oklahoma Applicants Only**: A consumer investigative report will be obtained through General Information Services, Inc., PO Box , Chapin, SC 29036. If an **investigative consumer report** and/or consumer report is processed, I understand that I am entitled to receive a copy.*

I have indicated below whether I would like a copy. Yes _____ No_____ Please check the box that applies

Date: _____ *Signature of Applicant:* _____

Print Name: _____