

**REQUISITION FOR AGENT APPOINTMENT**

**TYPE OF APPOINTMENT**

Agent:

Agency:

**INDIVIDUAL INFORMATION**

Last Name:			
First Name:			
Middle Name:			
SS#:	Birth Date:	Birth Place:	
Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>	Phone:	Email:	
Physical Resident Address:			City:
County:	State:	ZIP:	

**BUSINESS INFORMATION**

Agency/Firm Name:			TAX I.D. #:
Phone:	Fax:	Email:	
Physical Business Address:			City:
County:	State:	ZIP:	

I would like to be appointed by the following IHC Group carrier(s), please check all that apply:

- Standard Security Life Insurance Company of New York
- Madison National Life Insurance Company, Inc.
- Independence American Insurance Company

I would like to be appointed by Companion Life Insurance Company:

List the state(s) in which you are licensed and want to be appointed in:

State:	License #:
State:	License #:
State:	License #:
State:	License #:
State:	License #:
State:	License #:

Name of Manager/Administrator/General Agent:

**BACKGROUND - Use separate page if needed**

1. Do you carry Errors and Omissions Protection? Yes  No

2. Have you ever been:

- (a) convicted of any criminal felony, involving fraud, dishonesty or a breach of trust Yes  No
- (b) convicted of an offense under the Violent Crime Control and Law Enforcement Act of 1994; Yes  No
- (c) subject to a complaint filed against you by a state or a provincial Insurance Department? or Yes  No
- (d) subject to disciplinary proceeding of any federal or state regulatory agency? Yes  No

If yes, provide explanation below:

3. Are you bonded? Yes  No



**Commission Assignment**

*I direct my compensation to be made payable as follows:*

Agent Name: First Insurance Corporation      SSN TIN#: 86-0885551

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Dated at (City/State): \_\_\_\_\_ on \_\_\_\_\_, 20 \_\_\_\_\_

Producer Signature: \_\_\_\_\_

Producer Name: (Please Print): \_\_\_\_\_

*If not completed, commission will be paid to the Producer.*

**PLEASE ATTACH ALL COMMISSION SCHEDULES TO THIS FORM WHEN  
SUBMITTING TO IHC HEALTH SOLUTIONS, INC.**

**Please refer questions concerning this form to your MGA/GA  
Or to  
Agent Contracting: 800-920-7125**

In the event of any conflict between the applicable Producer Agreement and this Hierarchy Form, the Producer Agreement shall control. Nothing contained herein shall be deemed to limit the rights of Company under the Producer Agreement