Health Trust Financial
2000 Berryhill Rd
Montgomery, AL 36117
Phone: (770) 917-9393
red@healthtrustfinancial.com

Recruiter:_____

INFORMATION QUESTIONNAIRE

WE WELCOME YOU AS A MEMBER OF OUR TEAM FOR PROMPT PROCESSING, PLEASE PRINT

APPLICANT INFORMATION

Social Security Number/Federal ID Number

Birthdate (optional)

Applicant Name (Last, First, M.I.)

Company Name (Optional)

Address

Daytime Phone Number

Address

Evening Phone Number

City State Zip

Cell Phone Number

Email Address

FAX Number

LICENSE INFORMATION

License Number

Expiration Date of License

Type of License

State of License

SHIP TO: (For WELCOME PACK / UPS)

Ship to Name

Daytime Telephone Number

Ship to Address

City State Zip

BACKGROUND

The following questions MUST be answered, or the application will be returned:

1. Has your insurance license, from any state, ever been suspended or revoked? ☐ Yes ☐ No
2. Have you ever been convicted of a felony? ☐ Yes ☐ No
3. Have you ever declared any form of bankruptcy? ☐ Yes ☐ No
   If yes, give type and date of filing.

Answering YES *to any question would not preclude your acceptance as an Associate.*

I hereby acknowledge that I have received a copy of the General Agent Contract. I commit to uphold the spirit of intent and values contained herein. I have read, understood, and agree to abide by the General Agent Contract. I certify that the foregoing statements are true and correct to the best of my knowledge and belief. I hereby grant any licensed agent or employee of Health Trust Financial or company for which Health Trust Financial acts as general agent or wholesaler, permission to receive this Application and to verify such answers. I understand that any false statements on this application may be considered as sufficient cause for rejection, or for termination if such false statement are discovered. If accepted, I agree to comply with all of the rules and regulations of the Department of Insurance.

_____ _____

GENERAL AGENT'S SIGNATURE DATE

GENERAL AGENT CONTRACT

This General Agent Contract, and the Commission Schedule(s) attached hereto and made a part hereof for all purposes (collectively referred to as this "Contract"), made on this_____day of_____, 20____, by and between HEALTH TRUST FINANCIAL, L.L.C., on behalf of itself and its affiliates (collectively referred to as "Company"), and _____, (hereinafter referred to as "General Agent") for the purpose of soliciting applications for healthcare expense sharing ministry programs ("Sharing Programs") offered by the Company, including Medi-Share, a healthcare sharing ministry program offered by Christian Care Ministry, Inc. ("CCM").

I. INDEPENDENT CONTRACTOR

It is expressly agreed that the relationship intended by this Contract between General Agent and Company shall be that of an independent contractor only, and General Agent shall not be characterized as a partner, associate, affiliate or employee of the Company.

II. MANNER OF CONDUCTING BUSINESS

A. General Agent will be free to exercise its own judgment as to the time and manner of performing the services authorized by this Contract, except as otherwise specified herein and subject to such rules and regulations as may be adopted from time to time by the Company. General Agent's clientele may be developed by it by any lawful means. It shall select its own hours and workdays and is under no obligation to account to the Company for its time. Company may hold sales meetings to acquaint the General Agent with new Sharing Programs and sales techniques for the benefit of the General Agent. However, attendance at sales meetings will be optional and the expenses of attendance shall be the sole responsibility of the General Agent. General Agent shall be free to exercise its own judgment as to the time, routine, place, and method and manner it solicits applications for Sharing Programs, subject to applicable rules and regulations. General Agent agrees to grant the Company the right of first refusal on all applications. General Agent shall not solicit outside the jurisdiction for which it is licensed or contrary to the laws or regulations of the states where it operates.

B. The Company may from time to time make available to the General Agent supplies, leads, name lists, advertising matter and other material designed to assist General Agent in soliciting applications for Sharing Programs. All such material and other member information, whether past, current or prospective, acquired by General Agent shall remain the sole property of the Company, shall not be duplicated and shall be returned to the Company within five (5) days after the termination of this Contract.

agreed to by the parties within twenty (20) days of receipt by respondent of the request for arbitration or default thereof, appointed by the AAA in accordance with its Commercial Rules. The exclusive venue of arbitration shall be Montgomery, Alabama.

XX. CONFIDENTIALITY

Each party agrees not to disclose the terms of this Contract or the Commission Schedule to any third party without the prior written consent of the other party hereto, except as required by law. Further, each party agrees that it will keep confidential and not disclose any confidential or proprietary information of the other party or of the applicable healthcare sharing ministry, regardless of how the information was obtained, to any third party, except as required by law. Such confidential or proprietary information includes member names and other identifying information, medical records and business information.

IN WITNESS WHEREOF, this Contract has been signed by the parties hereto as of the date first set forth above.

_____	_____
Signature of Agent	Health Trust Financial
	By:_____
_____	_____
Date	Date

Commission Schedule

The undersigned agent/representative (the "Representative") agrees to the following Commission Schedule in connection with the solicitation of product offerings and membership programs authorized by Health Trust Financial, L.L.C. (the "Company"), subject to the terms and conditions set forth in the General Agent Contract and below:

Commission Table:

COMMISSION RATE FIRST YEAR OF MEMBERSHIP	COMMISSION RATE SECOND YEAR OF MEMBERSHIP	COMMISSION RATE THIRD YEAR OF MEMBERSHIP
8%	4%	2%

Commissions shall not be earned or paid on after third year.

The commission shall be equal to the Monthly Net Contribution multiplied by the applicable commission rate set forth above. Excluded from such commission calculation shall be any payments or deposits attributable to application fees, new joiner fees, change fees or other similar amounts. Commissions shall be due and payable sixty (60) days following the end of the month in which the member's Monthly Share is actually paid or deposited. No commission shall be payable for any month in which a member does not make a Monthly Net Contribution. Commissions shall cease as to any member who does not remit a Monthly Net Contribution for two consecutive months. Notwithstanding anything herein to the contrary, commissions are payable only out of proceeds from Monthly Net Contributions received by the Company from the applicable healthcare sharing ministry. For purposes of this schedule:

1. "Monthly Net Contributions" shall mean the gross Monthly Shares (as defined in Christian Care Ministry's Program Guidelines dated February 1, 2016) actually deposited by members with the healthcare sharing ministry, less (a) terminated or rescinded policies or memberships and (b) any other costs charged by the healthcare sharing ministry.
2. In the event of termination of the engagement of the Representative by the Company for any reason, commissions payments shall cease immediately and all rights to future commission shall be forfeited. In the event of a voluntary termination of the engagement by the Representative, commission payments shall continue to be paid for a period of no longer than twelve (12) months following the date of such voluntary termination.
3. The parties agree that no agency fees, administrative fees or other fees not specifically authorized by the health care sharing ministry shall be charged by the Representative relative to enrolling members in any healthcare expense sharing program.

_____ _____

AGENT/REPRESENTATIVE SIGNATURE DATE

Direct Deposit Authorization / Change Form

☐ New ☐ Change / Update Name: _____

I hereby authorize *(herein called COMPANY)* _____

to initiate automatic credit entries (Direct Deposits) to my account at the financial institution named below, herein called DEPOSITORY. I also authorize the same company to make withdrawals from this account(s) in the event that a credit entry is made in error.

Further, I agree not to hold the company responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until the company receives a written notice of cancellation from me or my financial institution in such time and in such manner as to afford the COMPANY and DEPOSITORY a reasonable opportunity to act upon it, or until I submit a revised direct deposit form.

Financial Institution: _____

Routing #: _____ Account #: _____ ☐ Checking ☐ Savings

Note - Attach a VOIDED check from the account (s) to be used for Direct Deposit. This ensures the correct information is obtained. Deposit Tickets/Slips are not acceptable as these may not contain the bank's external routing number information.

Date: _____ Signature _____

Print Form

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.

AGENT BUSINESS TRANSMITTAL AND AFFILIATION FORM

The current Agent of Record may designate that a new Agent/General Agent of Record be established for the type of membership identified below. The change of payment to an Agent or General Agent will only be applicable to future commissions payable after we have processed this form. You can only name a new Agent/General Agent of Record for business that you are the current Agent of Record on.

Agent Name (please print)	SSN	HTF Number
Business Address		
Email		

Medishare, Senior Assist or Any Other CCM Programs
PAY TO: Agent/General Agent Number
SSN:
Healthtrust Financial Number

☐ Effective immediately, the above agent or agency shall be affiliated with the following General Agent (GA),

listed below, for all Medishare/CCM Programs

General Agent Information

General Agent Name	HTF Number
Addres s	Phone Number

This form may only be agreed to and signed by the Agent of Record who is currently receiving commissions on the above referenced memberships. As the Agent of Record (AOR) I am requesting that the AOR be changed. The party to receive commissions must have a valid Healthtrust Financial/Medishare Agent/General Agent Contract on file and be properly licensed and appointed by Healthtrust Financial to receive commissions. 1099 forms will reflect the amount of compensation that the Agent/General Agent of Record received for any given year. All business and and commissions are subject to the terms and provisions of the Agent/General Agent Contract. The Agent of Record on a membership can only be changed by the current Agent of Record. Once completed, please fax this form to Healthtrust Financial at **(334)395-8509** or email the completed form to kim@healthtrustfinancial.com.

Agent Signature	**Date**