Appointment Application

UnitedHealthcare Insurance Company and Affiliates

UnitedHealthcare Medicare Solutions

THIS IS A WRITABLE FORM*

Please Print or Type: All fields must be complete and legible

Individual Information (All Individual Information fields required for all Appointment Applications).			
Legal Name (As name appears on Individual Resident State Insurance License) Last: Middle First:			
Social Security Number	Birth Date (MM/DD/YYYY)	Alias/Other Names:	
Resident Address			
City	State	County (FL Only)	Zip Code
Resident Phone Number	Business Phone Number	Fax Number	
Email Address			
Appointment Type: ☐ Individual OR ☐ Corporation	This must match information provided on the Agreement and W-9.		
Mailing Preference: ☐ Residential OR ☐ Business	If applying as an individual, but prefer mail be delivered to your business, fill in the Business Address section below.		

If Applying as a Corporation, the following information is also required. (You must be a Principal of the Corporation to Apply).			
Corporation Name	Principal		
Corporate Tax ID	Business Phone		
Business Address			
City	State	County	Zip

Errors and Omissions Attestation of Coverage ($1,000,000 per occurrence or 1,000,000 annual aggregate required)	
Name of Carrier	Policy #

By signing this attestation I am agreeing that I have met, and will maintain, the required Errors and Omissions coverage during my contract with UnitedHealthcare. I understand that failure to have met and maintained the Errors and Omissions coverage requirements will result in immediate termination.

Applicant's Signature: _____ SIGNATURE

NOTE: Failure to accurately and honestly answer any of the following questions may result in a declination of your application and appointment with UnitedHealthcare

If you answer "Yes" to any of these questions, please provide supporting documentation and a brief explanation on the next page of this form.

Criminal Background Information

1. Have you ever been convicted of a felony? ☐ Yes ☐ No
2. Have you ever been convicted of a misdemeanor (other than traffic) including an alcohol or drug-related offense? ☐ Yes ☐ No
3. Have you had your driver's license revoked within the past three years? ☐ Yes ☐ No

Department of Insurance and CMS

4. Have you ever had your insurance or securities license revoked and/or suspended by any department of insurance (even if later reinstated) for any reason? ☐ Yes ☐ No
5. Have you ever had a complaint reported against you (even if dismissed) by a consumer and/or insurance company for any reason with any department of insurance, FINRA, or other regulatory reporting agency including CMS? ☐ Yes ☐ No
6. Have you ever paid a fine related to a consumer complaint, failure to renew your license or continuing education credit in excess of $500? ☐ Yes ☐ No
7. Have you ever been excluded, or are you aware of actions that could result in an exclusion, by the Office of Inspector General from participation in a government health care program, including Medicare and Medicaid? ☐ Yes ☐ No

Credit History

8. Have you filed for bankruptcy and/or had a bankruptcy discharged within the last five years? ☐ Yes ☐ No
9. Are you, at the present time, or have you been within the past five years, involved in any civil litigation, judgements, liens orforeclosures? ☐ Yes ☐ No
10. Are you, at the present time, or have you been within the past five years, reported as delinquent on state or federal taxes? ☐ Yes ☐ No

Other Companies

11. Do you owe any insurance company, marketing organization or individual for any premiums collected or monies advanced? ☐ Yes ☐ No
12. Have you ever been denied an appointment with any insurance company? ☐ Yes ☐ No
13. Have you ever been terminated for cause by any insurance carrier? ☐ Yes ☐ No
14. Have you been denied a bond or application for errors and omissions (E&O) coverage with any company ☐ Yes ☐ No

Other

15. Do you have other information related to criminal, insurance-related complaints, credit, etc., that was not covered by these questions that you wish to disclose? ☐ Yes ☐ No

Please provide an explanation for any "Yes" answers on the previous page in the corresponding sections below.

Criminal Background Information

Department of Insurance and CMS

Credit History

Other Companies

Other

Conditions and Agreements

I have thoroughly reviewed this application and have answered all questions to the best of my knowledge. By signing below, I hereby attest to all matters set forth above and agree to all matters set forth below.

I hereby agree that if and when any or all of the companies issue to me any Agreement(s) for which I hereby apply, I will be bound by such Agreement(s). I understand that my supervising office has specimen forms of the Agreement(s) on file and I have had the opportunity to review such Agreement(s). Submitting to the Company any application for insurance products, including but not limited to Medicare Advantage and Prescription Drug Plan, shall constitute my agreement to such Agreement(s) and all the terms, conditions and provisions set for therein.

I Acknowledge that by signing this Appointment Application and submitting any such insurance application for Insured Product, I have so agreed to the Agreement(s) and no future signature by me shall be necessary.

Disclosure

I have executed this Appointment Application as evidence of the understanding and acceptance of, and consent to its terms, and I agree that I will not solicit business until I receive notification from the Company that this acknowledgement has been approved and I have satisfied all the of certification requirements of the products I intend to sell.

I understand that as part of its approval process and throughout the term of my appointment with the Company, the Company may obtain an investigation consumer report to confirm information regarding my character, general reputation, credit history, personal characteristics, mode of living, criminal history, insurance licensing history, Office or Inspector General records and General Service Administrator excluded party records. I hereby authorize the Company to obtain such a report at any time after receipt of this Appointment Application and throughout the term of my appointment with the Company. The scope of this authorization is all-encompassing, allowing the Company to obtain from any outside organization all manner of investigative consumer reports now and throughout my appointment to the extent permitted by law.

I understand that failure to accurately and honestly respond to any of the questions or attestations may result in a declination of my application and appointment with UnitedHealthcare.

Applicant's Signature	Date (MM/DD/YYYY)	SIGNATURE

Please return all documents to your Recruiter for submission to UnitedHealthcare.

Form **W-9**
(Rev. August 2013)
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.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:

☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

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

☐ Other (see instructions) ▶

Exemptions (see instructions):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

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

Requester's name and address (optional)

City, state, and ZIP code

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 the "Name" line to avoid backup withholding. For individuals, this is 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 chart on page 4 for guidelines on whose number to enter.

Social security number

			–			–				

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. The IRS has created a page on IRS.gov for information about Form W-9, at *www.irs.gov/w9*. Information about any future developments affecting Form W-9 (such as legislation enacted after we release it) will be posted on that page.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, payments made to you in settlement of payment card and third party network transactions, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

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.

Note. If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

UNITEDHEALTHCARE INSURANCE COMPANY
AGENT AGREEMENT

This AGENT AGREEMENT (this "Agreement") is made and entered into this ____ day of _____, 20___, by and between UnitedHealthcare Insurance Company ("United"), on behalf of itself and its Affiliates (collectively, the "Company") and _____ ("Agent").

A. United and certain of its Affiliates offer Medicare Advantage Plans ("MA Plans"), stand-alone prescription drug plans ("PDP Plans"), Medicare supplement insurance plans ("Med Supp Plans") and other health plans and products as may be designated by the Company (collectively, "Products").

B. FMO/NMA or General Agent has recommended Agent for appointment by the Company to market and promote the Products.

NOW, THEREFORE, in consideration of the mutual covenants in this Agreement, it is agreed as follows:

ARTICLE ONE
DEFINITIONS

As used herein, capitalized terms shall have the meanings set forth below:

1.1 **Affiliate** is any entity which directly or indirectly, through one or more intermediaries, owns or controls, is controlled or owned by or is under common ownership or control with the Company, and offers one or more of the Products. Affiliates offering the Products are specifically set forth in the Agent Compensation Schedule attached hereto and incorporated herein as **Exhibit A**.

1.2 **Agent** is an appropriately licensed, independent contractor, appointed by the Company, free to exercise his or its own judgment as to the time and manner of performing services pursuant to an agreement between the Agent and the Company.

1.3 **CMS** is the Centers for Medicare & Medicaid Services.

1.4 **CMS Contract** is the contract entered into by CMS and the Company pursuant to which the Company offers one or more MA Plans and/or one or more PDP Plans in a specified service area or region.

1.5 **FMO/NMA** is a Field Marketing Organization or National Marketing Alliance that has contracted with the Company to promote the Products and has directly or indirectly through a General Agent recommended Agent for appointment by the Company to market and promote the Products.

1.6 **General Agent** is an appropriately licensed, independent contractor, appointed by the Company, free to exercise his or its own judgment as to the time and manner of performing services pursuant to an agreement between the General Agent and the Company and authorized to recommend Agent for appointment by the Company to market and promote the Products. A General Agent can be categorized in any one of three levels, General Agent (GA), Super General Agent (SGA) or Master General Agent (MGA).

1.7 **MA Organization** is an entity that has entered into a contract with CMS to operate an MA Plan.

1.8 **MA Plan** is any Medicare Advantage Plan that may now or in the future be offered to individual Medicare beneficiaries by the Company including, but not limited to, Local HMO and PPO Plans ("Local MA Plans"), Special Needs Plans ("SNPs"), Regional Preferred Provider Plans ("Regional PPO Plans") and Private Fee for Service Plans ("PFFS Plans"). The definition of an MA Plan includes an MA Plan which includse prescription drug plan benefits ("MA-PD Plans").

The following exhibits and attachments are incorporated by reference into this Agreement:

__ **Exhibit A** Agent Compensation Schedule
__ **Exhibit B** Medicare Regulatory Addendum
__ **Exhibit C** HIPAA Business Associate Addendum
__ **Exhibit D** Branded Products Addendum

Executed this _____ day of _____, 20___.

AGENT CONTRACTING AS

UNITEDHEALTHCARE INSURANCE COMPANY, on behalf of itself and its Affiliates

(Check one)

- ☐ **INDIVIDUAL**
- ☐ **PARTNERSHIP**
- ☐ **CORPORATION**

_____
Print Name on License

By: _____
Authorized Signature

By: _____
Company Officer

Title: _____

Title: _____

_____
Address

_____ ____ _____
City State Zip Code

National Producer Number (required): _____