# Broker Application

## I. INSTRUCTIONS

**This form should be typed or legibly printed in black or blue ink**. If more space is needed than provided on original, attach additional sheets and reference the question being answered. Please do not use abbreviations when completing the application. **Current copies of the following documents must be submitted with this application:**

- ☐ Proof of State Insurance License
- ☐ Proof of Errors & Omissions Coverage
- ☐ W – 9 Form
- ☐ Confidentiality Agreement
- ☐ Statement of Understanding
- ☐ Broker Agreement

## II. IDENTIFYING INFORMATION

| **Last Name:** | **First Name:** | | **M.I.:** |
|---|---|---|---|
| Mailing Address (*for payment*): | City: | | |
| | State: | ZIP: | |
| Home Address: | City: | | |
| | State: | ZIP: | |
| Telephone Number:<br>Fax Number: | E-Mail:<br>Cell Number: | | |

## III. OTHER INFORMATION

| | |
|---|---|
| **Sex:** ☐ Male ☐ Female | **Marital Status:** ☐ M ☐ S ☐ D |
| Service Area by County: ☒ Los Angeles ☒ San Bernardino ☒ Orange ☒ Riverside | |
| Education: ☐ Graduate School ☐ College ☐ High School ☐ Grade School | Occupation: |
| | Date of Birth: |
| Social Security #: | License Number: |

## IV. ERRORS & OMISSIONS COVERAGE

| Current Insurance Carrier: | Policy Number: | Original Effective Date: |
|---|---|---|
| Mailing Address: | City: | |
| | State: | ZIP: |
| Per Claim Amount: $ | Aggregate Amount: $ | Expiration Date: |

**Background - Please provide complete explanation of any "Yes" answers on a separate sheet:**

☐ Yes ☐ No 1. Have you ever plead guilty or been found guilty of a felony or crime, including but not limited to, crimes involving dishonesty, breach of trust, violation of any Federal law, or are you now under indictment?

☐ Yes ☐ No 2. Are you at present involved in any litigation or are there any unsatisfied judgments or liens (including State & Federal tax liens) against you?

☐ Yes ☐ No 3. Have you violated any Plan, Federal or State laws, rules and regulations in Marketing?

☐ Yes ☐ No 4. Do you owe an insurance company or other person for any premiums collected or monies advanced?

☐ Yes ☐ No 5. Have you ever had your insurance or securities license suspended or revoked or have you ever had any insurance department?

☐ Yes ☐ No 6. Have you ever had a complaint filed against you with an insurance department, NASD or other regulatory agency or do you anticipate one being filed or have ever been terminated by any company for cause?

☐ Yes ☐ No 7. Has any company or other person alleged that it has not received premiums or other monies due such company or person from you?

☐ Yes ☐ No 8. Are you a first degree relative of a CMS provider? If yes, please specify the relationship (i.e. daughter, son or spouse): ___________________________

CENTRAL HEALTH PLAN OF CALIFORNIA

**BROKER**
**CONDITIONS AND AGREEMENTS**

- I hereby affirm that I have reviewed this application and have answered all questions to the best of my knowledge.
- 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, such Agreement(s) will bind me.
- I understand and agree that I have the opportunity to review such Agreement(s) and contract renewal term is contingent upon my annual completion of Marketing Training provided by Plan.
- I understand and agree that I have executed this Broker application as evidence of the understanding, acceptance and consent of its terms, and I agree that I will not solicit business until I received notification from the Company of acknowledgement and approval.
- I understand and agree that as an applicant, have the burden of producing adequate information for proper evaluation of professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.
- I understand that as part of its approval process, the Company may obtain an investigative consumer report which will confirm information regarding my character, general reputation, credit history, personal characteristics and mode of living, thus hereby authorize the Company to obtain such report.
- I understand that providers who receive payment from Medicare (i.e. Physicians, Pharmacists, Physical Therapists, and Provider Relatives, which include but are not limited to, spouses, sons, daughters, and others) are not qualified to enroll eligible Medicare beneficiaries into a Medicare plan.

I hereby affirm that the information submitted in this application and any addenda thereto is true, current, and correct, completed to the best of my knowledge and belief, and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my Agreement(s).

Print or Type Your Name Here: ____________________________________________

Your Signature: ____________________________________________


Today's Date: ____________________________________________

CENTRAL HEALTH PLAN OF CALIFORNIA

5. **Irreparable Harm.** The Broker understand and acknowledge that any disclosure or misappropriation of any of the Confidential Information in violation of this Agreement may cause the PLAN irreparable harm, the amount of which may be difficult to ascertain, and therefore agrees that the PLAN shall have the right to apply to a court to competent jurisdiction for specific performance and/or an order restraining and enjoining any such further disclosure or breach and for such other relief as the PLAN shall deem appropriate. Such right of the PLAN is to be in addition to the remedies otherwise available to the PLAN at law or in equity. The parties expressly waive the defense that a remedy in damages will be adequate and requirement in an action for specific performance or injunction for the posting of a bond by the other.

6. **Survival.** This Agreement shall continue in full force and effect at all times.

7. **Governing Law.** This Agreement shall be governed by and construed in accordance with the laws of the State of California. The parties hereby irrevocably consent to the jurisdiction of the state and federal courts located in Los Angeles County, California, in any action arising out of or relating to this Agreement, and waive any other venue to which either party might be entitled by domicile or otherwise.

8. **Attorney's Fees.** If any action at or in equity is brought to enforce or interpret the provisions of this Agreement, each party shall be responsible for the reimbursement of Attorney's fees and cost.

9. **Entire Agreement.** This agreement expresses the full and complete understanding of the parties with respect to the subject matter hereof and supersedes all prior or contemporaneous proposals, agreements, representations and understandings, whether written or oral, with respect to the subject matter. This Agreement is not, however, to limit any rights that the parties may have under trade secret, copyright, patent or other laws that may be available to the parties. This Agreement may not be amended or modified except in writing signed by each of the parties to the Agreement. This Agreement shall be construed as to its fair meaning and not strictly for or against either party. The headings hereof are descriptive only and not to be construed in interpreting the provisions hereof.

10. **Counterparts.** This Agreement may be signed in counterparts, which together shall constitute one agreement.

**PLAN**

Signature: ______________________

Name: ______________________

Title: ______________________

Date: ______________________

**BROKER**

Signature: ______________________

Name: ______________________

Title: ______________________

Date: ______________________



Rev. 10.26.09

**CENTRAL HEALTH PLAN OF CALIFORNIA**

# CONTRACTED BROKER STATEMENT OF UNDERSTANDING

I certify that I have read and understand the Central Health Plan of California, Inc. ("CHPC") Code of Conduct and Anti-Fraud Plan, and agree to abide by them during the entire term of my contract with CHPC.

I also certify that I have not been convicted of, or charged with, a criminal offense related to health care, nor have I been listed by a federal agency as debarred, excluded or otherwise ineligible for participation in federally funded health care programs.

I understand that violation of any law, regulation, the CHPC Code of Conduct, or the CHPC Anti-Fraud Plan is grounds for disciplinary action, up to and including contract termination.

I agree to report the violation or suspected violation of any law, regulation, the CHPC Code of Conduct, or the CHPC Anti-Fraud Plan to CHPC's Compliance Officer as described on page 5 of the CHPC Code of Conduct. I understand that failure to report any such violation or suspected violation of which I become aware is grounds for disciplinary action, up to and including contract termination.

Unless otherwise noted in the space immediately below, I am not aware of any possible violations of laws, regulations, the CHPC Code of Conduct, or the CHPC Anti-Fraud Plan at this time.

| |
|---|
| |

Date ____________ Signature ____________ SIGN HERE

____________ Print/Type Name

**Please return this form to** CHPC Marketing Department (name) **no later than** ____________ (date)