AGENT INFORMATION

Social Security #

Full Name

LAST FIRST MIDDLE SUFFIX TITLE

Correspondence Name — Sex Male: ☐ Female: ☐ — Date of Birth

Primary Phone — Secondary Phone — Fax #

BUSINESS ADDRESS

Agency Name — (For mailing purposes only)

Street

City — State — ZIP — County

SHIPPING ADDRESS (must be street address)

Same as Business Address ☒ Yes ❑ No

Agency Name — (For mailing purposes only)

Street — PO Box

City — State — ZIP — County

RESIDENT ADDRESS

Street

City — State — ZIP — County

BUSINESS INFORMATION

List the name(s) of other Insurance Companies you represent

How were you referred to Humana?

E-MAIL ADDRESS

(required information) ______________________________

AGENT OR AGENCY AFFILIATION (Name of agent or agency you are working with, if applicable.)

Name

Fed. Tax ID # or SS #

Address

Agent information form continued on page 4

Commission Payments

If directing your commissions to an agency, complete the Agent Business Transferral Form (Appendix, page 43).

Note that additional contract booklet for agency will need to be completed.

Direct Deposit

If you would like to sign up for Direct Deposit of your commissions, please complete the Direct Deposit form (Appendix, page 45).

Group Producing Agent or Agency Contract

Applicable Companies
- Humana Insurance Company
- Humana Health Plan, Inc.
- and all of their affiliates

The Applicable Companies
(hereinafter referred to as the "Company") and

X of **X**

(agent or agency name) (city) (state)

(hereinafter referred to as "GPA"),
IN CONSIDERATION of the mutual promises and agreements set forth herein below, hereby enter into this Group Producing Agent or Agency Contract which shall include all amendments to this Group Producing Agent or Agency Contract, current and future Exhibits, Attachments, Producer Partnership Plans and other written agreements which may be entered into by the parties (collectively the "Contract") and AGREE AS FOLLOWS:

1. APPOINTMENT AND RELATIONSHIP

A. The Company hereby appoints the GPA to act on its behalf and represent it only to the extent authorized herein.

B. The GPA is an independent contractor with respect to the Company, and nothing contained herein shall create or be construed to create the relationship of employer and employee between the Company and the GPA or between the Company and any employee of the GPA.

2. AUTHORITY AND RESPONSIBILITY OF GPA

A. The GPA is hereby authorized on behalf of the Company, but only in those states where the Company is authorized to do business and provided that the GPA is in compliance with all applicable regulatory licensing requirements at the time of solicitation, to solicit applications for the approved products offered by the Company which are listed in Producer Partnership Plan or other written documents provided to the GPA by the Company, which are made a part of this Contract.

B. The GPA is authorized to collect the initial payment only for any policy or contract issued upon application solicited by the GPA, and to deliver and service policies, contracts and certificates of group coverage so issued, provided:

1. receipts for such payments shall only be given on forms furnished by the Company for that purpose.
2. all such payments shall be received and held in a fiduciary capacity by the GPA as trustee for the Company.
3. all checks should be made payable to the Company unless the GPA receives prior permission from the Company to the contrary, and in no event is any GPA authorized to accept any check in excess of $5,000 not specifically made payable to the Company.

C. The GPA may not use the Company's name, logo or any proprietary information on any printed or electronic advertising or Internet site without prior written approval of the Company. The GPA may create an electronic link from the GPA's Internet site to the Company's Internet sites, but the GPA may not reproduce any of the Company's Internet content or programs on the GPA's Internet sites. The GPA may not alter any materials considered proprietary by the Company in electronic, printed or any other form.

D. GPA must fully and accurately represent to all parties the terms and conditions, including limitations and exclusions, of the products and services of the Company, consistent with and according to Company marketing materials, certificates of insurance, subscriber and group contracts, insurance policies and benefit plans.

E. The GPA is hereby authorized to refer to the Company, potential applicants for Medicare policies, including Medicare HMO and Medicare Supplement. The names of individuals potentially eligible for Medicare policies may be referred only in Company approved service areas, in which Company is authorized to do business. Any referral must be performed consistent with the Company's Medicare referral program, this Contract, and all applicable laws. The GPA must be licensed in the state that has jurisdiction over the transaction, and appointed on behalf of the Company. The GPA will refer the name of any prospect, and the source of the lead, to authorized Company Medicare Sales Personnel. A GPA who makes a Medicare referral is not the "Agent of Record" for the Medicare policy.

BACKGROUND INFORMATION

List your occupation/employment for the past five years, most recent first.

FROM Mo/Yr	TO Mo/Yr	EMPLOYER NAME/ADDRESS	DUTIES	REASON FOR LEAVING

BACKGROUND QUESTIONS

		Yes	No
A.	Are you presently indebted to any insurer or any insurance company or managing general agent?	❏	❏
B.	Are there any criminal charges pending against you?	❏	❏
Have you ever:		Yes	No
C.	been the subject of any investigation or proceeding by any insurance department?	❏	❏
D.	had any agency contract or company appointment canceled for cause (e.g. misrepresentation, misappropriation, etc.)?	❏	❏
E.	been suspended, expelled, fined, barred, censured or otherwise disciplined or found to have violated any law or rule by any insurance department or by any party in the insurance industry?	❏	❏
F.	been refused a license to sell insurance or membership in any organization or had a license suspended or revoked by any insurance department?	❏	❏
G.	withdrawn any application or surrendered any license to avoid any disciplinary action or the denial of a license?	❏	❏
H.	been convicted of or pleaded nolo contendere to any felony or misdemeanor, except for traffic offenses? If yes, give complete information and attach copy of court order.	❏	❏
I.	gone through bankruptcy, had salary attached or had any liens or judgments outstanding against you?	❏	❏
J.	been named a party in any lawsuit?	❏	❏

For any "Yes" answers, please attach a detailed explanation.

ENCLOSE a copy of your state insurance license and/or appropriate state appointment form for the state(s) in which you will be selling Humana products.

FOR HUMANA USE ONLY

Authorized Signature ______________________________

Sales Representative (Territory) ______________________________

❏ Commercial ❏ Medicare (Facility # ____________________) ❏ Individual

3. Violation of the laws, regulations, or rules of any jurisdiction by the GPA in which the GPA operates, or of any governmental authority exercising jurisdiction over the GPA.

   Termination for "cause" may, at the option of the Company, result in forfeiture of all commissions which may be due under this Contract as of the termination date or become due thereafter.

C. On the effective date of a voluntary termination of this Contract by the GPA:

   1. The GPA shall be terminated as the agent for any policies the GPA has with the Company; and
   2. The GPA will no longer earn or receive commissions from the Company.

7. SIGNATURES

I hereby accept and am in possession of the Group Producing Agent or Agency Contract. I understand the Contract will not be in effect until such time when I am in receipt of the countersigned copy of the signature page of the Group Producing Agent or Agency Contract.

The undersigned parties agree to the terms of the Contract as specified herein, or as such terms may be amended from time to time.

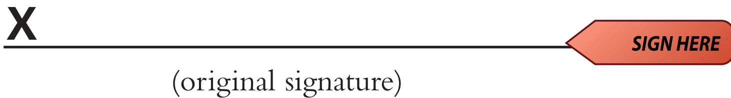
I represent that the information I have provided in this Contract including the Agent Information and Agency Information sections of this Contract is accurate, complete and true to the best of my knowledge and belief.

This Group Producing Agent or Agency Contract shall be governed by the laws of the State of Kentucky.

EXECUTED BY THE GROUP
PRODUCING AGENT OR AGENCY:

X ______________________________ (name – print or type)

X ______________________________ (street)



X ______________________________ (original signature)

X ______________________________ (city) (state)

X ______________________________ (date)

FOR HUMANA USE ONLY
(To be completed by Humana, not the agent or agency)

EXECUTED ON BEHALF OF THE
APPLICABLE INSURANCE COMPANY BY:

______________________________ (name - print or type)

______________________________ (title/at)

______________________________ (signature)

______________________________ (date)

This Contract shall take effect as of the __________ (day) of ____________________ (month), __________ (year).

HUMANA®
Guidance when you need it most

Group Producing Agent or Agency Contract

Applicable Companies
- Humana Insurance Company
- Humana Health Plan, Inc.
- and all of their affiliates

The Applicable Companies
(hereinafter referred to as the "Company") and

X ______________________ of X ______________________

(agent or agency name) (city) (state)

(hereinafter referred to as "GPA"),
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2. AUTHORITY AND RESPONSIBILITY OF GPA

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B. The GPA is authorized to collect the initial payment only for any policy or contract issued upon application solicited by the GPA, and to deliver and service policies, contracts and certificates of group coverage so issued, provided:

1. receipts for such payments shall only be given on forms furnished by the Company for that purpose.
2. all such payments shall be received and held in a fiduciary capacity by the GPA as trustee for the Company.
3. all checks should be made payable to the Company unless the GPA receives prior permission from the Company to the contrary, and in no event is any GPA authorized to accept any check in excess of $5,000 not specifically made payable to the Company.

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D. GPA must fully and accurately represent to all parties the terms and conditions, including limitations and exclusions, of the products and services of the Company, consistent with and according to Company marketing materials, certificates of insurance, subscriber and group contracts, insurance policies and benefit plans.

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3. Violation of the laws, regulations, or rules of any jurisdiction by the GPA in which the GPA operates, or of any governmental authority exercising jurisdiction over the GPA.

   Termination for "cause" may, at the option of the Company, result in forfeiture of all commissions which may be due under this Contract as of the termination date or become due thereafter.

C. On the effective date of a voluntary termination of this Contract by the GPA:

   1. The GPA shall be terminated as the agent for any policies the GPA has with the Company; and
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7. SIGNATURES

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The undersigned parties agree to the terms of the Contract as specified herein, or as such terms may be amended from time to time.

I represent that the information I have provided in this Contract including the Agent Information and Agency Information sections of this Contract is accurate, complete and true to the best of my knowledge and belief.

This Group Producing Agent or Agency Contract shall be governed by the laws of the State of Kentucky.

EXECUTED BY THE GROUP
PRODUCING AGENT OR AGENCY:

X ______________________________
(name – print or type)

X ______________________________
(street)

X ______________________________
(original signature)

X ______________________________
(city) (state)

X ______________________________
(date)

FOR HUMANA USE ONLY
(To be completed by Humana, not the agent or agency)

EXECUTED ON BEHALF OF THE
APPLICABLE INSURANCE COMPANY BY:

____
(name - print or type)

____
(title/at)

____
(signature)

____
(date)

This Contract shall take effect as of the __________ (day) of ______________________ (month), ____________ (year).

HUMANA®
Guidance when you need it most

Applied General Agency

AUTHORIZATION AGREEMENT FOR AUTOMATIC DEPOSIT

HUMANA
Guidance when you need it most

APPENDIX

I (We) hereby authorize Humana to initiate Automated Clearing House credits and, if necessary, make corrections for any entries made to my account in error.

AGENT INFORMATION

Agent or Agency requesting automatic deposit: ______________________

Social Security number/Tax ID number: ______________________

SAN number (if applicable): ______________________

Phone number: ______________________

Please indicate transaction type:

☐ Set-up ☐ Change ☐ Cancel

Please indicate type of account:

FINANCIAL INFORMATION

Bank Name: ______________________

Bank City: ______________________

State: ______________________ Zip: ______________________

Bank phone number: ______________________

Bank account number: ______________________

Bank routing number: ______________________

(Please provide the nine-digit routing number on your check, not the deposit slip.)

This authorization will remain in force until written notification of termination or change is received by Humana in such time and in such manner as to afford Humana a reasonable opportunity to act on it.

NOTE: Direct deposit set-up requires that the bank account and routing number must be verified for accuracy before any funds are transferred. For this reason, you may receive one or two commission checks that need to be cashed.

Print Name: ______________________

Title (owner/officer only): ______________________

Signature: ______________________ SIGN HERE Date: ______________________

Complete and fax this form to Humana Agency Management at 1-920-339-2160 if NOT completing a contract.

PLEASE INCLUDE A COPY OF A VOIDED CHECK

GN-62539-HH 2/10

Appointments for Specific Products

I am requesting to be appointed to represent specific products by resident and non-resident state as indicated by the "x". I understand that I must hold a valid health and/or life insurance license in the states requested to be appointed in those states *(include copy of licenses with submission).*

Resident State Requested: ________ **Non-Resident State(s) Requested**: ____________________________

(must be certified to sell) **Medicare Plans**	**Med. Supp.**	**HumanaOne Health**	**Dental Plans**	**Vision Plans**	*(includes Jr. Estate, Memorial Fund, Critical Illness, Cancer, Hosptial Indemnity, Life)* **Humana Financial Protection Plans***
X	X	X	X	X	X

** products not available in all states*

Acknowledgement

I have read, understand, and agree to the terms and provisions of this Group Producing Agent or Agency Contract Medicare Amendment and GPA Medicare Advantage Plans and Prescription Drug Plans Sales and Marketing Agreement as specified herein or as such terms may be amended from time to time.

I have read, understand, and agree to the Group Producing Agent or Agency Contract Medicare Amendment and GPA Medicare Advantage Plans and Prescription Drug Plans Sales and Marketing Agreement. I understand that violation of any part of the provisions of either document may be cause for termination of the GPA Medicare Advantage Plans and Prescription Drug Plans Sales and Marketing Agreement to sell the Company's MA plan(s) or PDP plan(s) and/or the Group Producing Agent or Agency Contract (GPA) including the Group Producing Agent or Agency Contract Medicare Amendment.

____
GPA Name

____
Humana MarketPOINT Vice President (PRINT)

Mailing Address

__________ ____ __________
City State Zip-code

____
Humana MarketPOINT Vice President Signature/Date

____
SSN / TIN

____
E-Mail Address

________ ____________
GPA – Signature / Date
Sales Office Name / State

CONSUMER AUTHORIZATION

APPLIED GENERAL AGENCY

I. I understand that an investigative report may be generated on me that may include information as to my character, work habits, performance and experience, along with reasons for termination of past employment/professional license or credentials; financial/**credit history**; or criminal/civil/driving record history. I fully give my consent to and understand that you, General Information Services, Inc., may be requesting information from public and private sources about any of the information noted earlier in this paragraph.

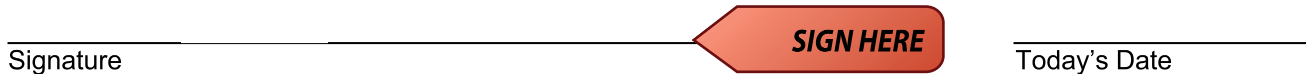
II. IF APPLICABLE, Medical and worker's compensation information will only be requested in compliance with the Federal Americans with Disabilities Act (ADA) and/or any other applicable state laws. According to the **Fair Credit Reporting Act** (FCRA, Public Law 91-508, Title VI) which was **revised effective September 30, 1997**, I am entitled to know if the considerations for which I am applying are denied because of information obtained from a consumer reporting agency. If so, I will be notified and be given the name of the agency providing that report.

III. I acknowledge that a telephonic facsimile (FAX) or photographic copy of this release shall be as valid as the original. This release is valid for most federal, state and county agencies including the Minnesota Department of Labor.

IV. **Minnesota/California applicants only**. If you want a copy of the report ordered, check this box *. The report will be sent by the consumer reporting agency to you at the address listed below your signature.

V. I hereby authorize, without reservation, any financial institution, law enforcement agency, information service bureau, school, employer or insurance company contacted by General Information Services, Inc. to furnish the information described in Section I.

APPLICANT COMPLETE THE FOLLOWING:



Signature ____________________ Today's Date ____________

Please print full name ____________________

The following information is required by law enforcement agencies and other entitles for positive identification purposes when checking public records. It is confidential and will not be used for any other purposes.

Please print other names you have used ____________ Social Security Number ____________ Date of Birth ____________

Home Address ____________ City ____ State ____ Zip ____

Driver's License Number and State ____________ Name as it appears on License ____________

Have you ever been convicted of a crime? ☐ No ☐ Yes If yes, please provide city and state of conviction and details of conviction.

____

FAIR CREDIT REPORTING ACT NOTICE:
In accordance with the Fair Credit Reporting Act (FCRA, Public Law 91-508, Title VI), **revised effective September 30, 1997** , this information may only be used to verify a statement(s) made by an individual in connection with legitimate business needs. The depth of information available varies from state to state. Status of updates are available on request. Although every effort has been made to assure accuracy, General Information Services, Inc. cannot act as guarantor of information accuracy or completeness. Final verification of an individual's identity and proper use of report contents are the user's responsibility. General Information Services, Inc.'s policy requires purchasers of these reports to have signed a Service Agreement. This assures General Information Services, Inc. that users are familiar with and will abide by their obligations, as stated in the **FCRA, revised effective September 30, 1997**, to the individuals named in these reports. If information contained in this report is responsible for the suspension or termination of an employee or the application process, have the applicant/employee contact General Information Services, Inc.