

EXHIBIT C
Agent Appointment Application



By completing this Agent Appointment Application, the undersigned is applying to be a non-exclusive agent to Molina Healthcare for purposes of marketing Molina Medicare. "Molina Medicare" collectively refers to the MA-PD plans offered by Molina Healthcare health plans in California, Washington, Utah, Nevada, New Mexico, Texas, Ohio and Michigan.

PLEASE PRINT CLEARLY

Name _____ Alias/Other Names _____

Social Security # _____ Tax ID _____

Corporation Name _____ Appointment Type Individual Corporation

Birth Date _____ Mailing Preference Home Business

Home Address _____	Business Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Home Phone _____	Business Phone _____

Fax Number _____ E-Mail (required) _____

Resident License State _____ License # _____

Non-Resident License States _____
(Attach copies of all licenses for appointment)

Errors and Omissions coverage Yes No Name of carrier _____

Coverage amount _____

Background – Please provide a complete explanation of any “yes” answers on a separate sheet:

- Yes No 1. Have you ever had your insurance or securities license suspended, revoked or subject to disciplinary action, or have you ever had an application for an insurance license denied by any insurance department?
- Yes No 2. Have you ever been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?
- Yes No 3. Have you ever pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?
- Yes No 4. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?
- Yes No 5. 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?
- Yes No 6. Have you been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?
- Yes No 7. Do you owe an insurance company or other person for any premiums collected or monies advanced?
- Yes No 8. 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 9. Do you agree to comply with CMS regulations for Medicare Advantage Organizations? Specifically, do you agree to avoid prohibited practices such as door to door marketing, offering inducements for enrollments or other unapproved promotional activities such as gift cards or cash incentives?
- Yes No 10. Do you agree to use ONLY marketing collaterals and advertisements that have been approved by CMS and Molina Healthcare in connection with marketing Molina Medicare?
- Yes No 11. Do you agree to refrain from engaging in misleading, confusing, or “high pressure” sales tactics as you market Molina Medicare?

Attestation and Agreement

By signing below, I attest I have thoroughly reviewed this Agent Appointment Application and have answered all questions to the best of my knowledge.

I acknowledge that by signing and submitting this Agent Appointment Application, I have agreed to comply with all of the terms and conditions of Molina Healthcare’s standard Producer Agreement, which includes a HIPAA Business Associate Agreement, and CMS Program Requirements. A copy of the Producer Agreement will be provided to me upon Molina Healthcare’s approval of this Agent Appointment Application.

I acknowledge that upon approval of this Agent Appointment Application, I will be an independent contractor, not an employee of Molina Healthcare. Accordingly, I will have no claim for vacation or sick leave, retirement benefits, Social Security, Workers’ Compensation benefits, disability or unemployment insurance benefits, or employee benefits of any kind.

I agree that I will not solicit individuals to enroll in Molina Medicare until I receive notification from Molina Healthcare that this Agent Appointment Application has been approved.

Applicant Signature _____  **Date** _____

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS (All states except California, Minnesota and Oklahoma)

This Disclosure and Authorization is provided to you in connection with your application (Agent Appointment Application) to Molina Healthcare (the "Company") for status as a non-exclusive agent to market the Company's Medicare Advantage product (Molina Medicare) in the approved service area/s to individuals who are eligible to enroll in a Medicare Advantage plan.

The Company desires to procure a consumer or investigative consumer report (or both) ("Background Reports") regarding your background for use by the Company or any legal affiliate (sister company or parent-subsidiary relationship) in evaluating your application for status as a non-exclusive agent. Any Background Reports requested pursuant to your Authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency ("CRA") that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to the Company. To obtain contact information regarding CRA or to submit a written request for more information, contact Mark L. Andrews, Esq., Chief Legal Officer, Molina Healthcare, Inc., 2277 Fair Oaks Blvd. #440; Sacramento, CA 95825; Fax 916-646-4572.

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act."

AUTHORIZATION: I have submitted an Agent Appointment Application to the Company. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to the Company and its affiliates for the purpose of evaluating my application for status as a non-exclusive agent. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to Verifications, Inc. retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law. I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and the Company will, in that event, forward such revocation promptly to Verifications, Inc. that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) written revocation as described above, or (ii) twelve (12) months following the date of my signature below. A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

(Print Full Name and Residence Address)

(Signature)

SIGN HERE

(Date)

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS (California)

This Disclosure and Authorization is provided to you in connection with your application (Agent Appointment Application) to Molina Healthcare (the "Company") for status as a non-exclusive agent to market the Company's Medicare Advantage product (Molina Medicare) in the approved service area/s to individuals who are eligible to enroll in a Medicare Advantage plan.

The Company desires to procure a consumer or investigative consumer report (or both) ("Background Reports") regarding your background for use by the Company or any legal affiliate (sister company or parent-subsidary relationship) in evaluating your application for status as a non-exclusive agent. Background Reports will be obtained through Verifications, Inc. Any Background Reports requested pursuant to your Authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may request more information about the nature and scope of Background Reports produced by any consumer reporting agency ("CRA") by submitting a written request to Company. You should submit any such written request for more information to Mark L. Andrews, Esq.; Chief Legal Officer, Molina Healthcare, Inc.; 2277 Fair Oaks Blvd. #440; Sacramento, CA 95825; Fax 916-646-4572.

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act." You will be provided with a copy of any Background Report procured by Company if you check the box below.

By checking this box, I request a copy of any Background Report from any CRA retained by Company, at no extra charge.

Under section 1786.22 of the California Civil Code, you may view the file maintained on you by the CRA listed above. You may also obtain a copy of this file, upon submitting proper identification and paying the costs of duplication services, by appearing at the CRA in person or by mail; you may also receive a summary of the file by telephone. Verifications, Inc. is required to have personnel available to explain your file to you and Verifications, Inc. must explain to you any coded information appearing in your file. If you appear in person, you may be accompanied by one other person of your choosing, provided that person furnishes proper identification.

AUTHORIZATION: I have submitted an Agent Appointment Application to the Company. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to the Company and its affiliates for the purpose of evaluating my application for status as a non-exclusive agent. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to Verifications, Inc. retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law. I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to Verifications, Inc. that either prepared or is preparing Background Reports under this Disclosure and Authorization. In no event, however, will this authorization remain in effect beyond twelve (12) months following the date of my signature below. A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

(Printed Full Name and Residence Address)

(Signature)  _____
(Date)