

Appointment Application

Field Marketing Organization (FMO) Channel
 United Healthcare Insurance Company and Affiliates



Type of Request: <input type="checkbox"/> New <input type="checkbox"/> Change		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 in insurance License)			
First:	Middle:	Last:	
Alias/Other Names		Social Security Number	Birth Date
Home Address			
City	State	County	Zip
Home Phone	Business Phone	Fax	
E-mail Address (required)			
Appointment Type: <input type="checkbox"/> Individual OR <input type="checkbox"/> Corporation		This must match information provided on the Agreement and the W-9.	
Mailing Preference: <input type="checkbox"/> Home OR <input type="checkbox"/> 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
Please list the states for which you are applying for appointment.*		*Must include resident state. *Listing a state does not guarantee appointment for that state. *Must be licensed in each state listed. *All states subject to individual review.	
Resident State		Non-Resident States	
Errors and Omissions Coverage			
AN ACTIVE POLICY DECLARATION PAGE WITH YOUR NAME LISTED AS THE COVERED ENTITY MUST BE ATTACHED.			
Name of Carrier			Expiration Date
Policy #		\$1,000,000 per occurrence and \$1,000,000 annual aggregate required.	

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 a separate sheet of paper.

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, NASD, 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, judgments, liens or foreclosures?..... 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

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 forth 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 of the certification requirements for the products I intend to sell.

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. I hereby authorize the Company to obtain such a report.

Applicant's Signature



Date



**Please return all documents to your
Field Marketing Organization (FMO) Recruiter
for submission to UnitedHealthcare.**

**UNITED HEALTHCARE INSURANCE COMPANY
AGENT AGREEMENT**

This AGENT AGREEMENT (this “Agreement”) is made and entered into this ____ day of _____, 20____, by and between United HealthCare 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, the “Products”).

B. FMO 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**

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 United, and offers one or more of the Products. Affiliates offering the Products shall be specified in the Agent Compensation Schedule attached hereto and incorporated herein as **Exhibit A** to this Agreement.

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

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

1.4 **Field Marketing Organization (FMO)** is an independent contractor, who or which has entered into a contract with Company for the marketing and promotion of the Products and has directly or indirectly through a General Agent recommended Agent for appointment by the Company to market and promote the Products.

1.5 **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 another agent for appointment as a General Agent, Agent or Solicitor Agent. A General Agent can be categorized in any one of three levels, General Agent (GA), Super General Agent (SGA) or Master General Agent (MGA) as set forth in the Relationship Hierarchy attached hereto and incorporated herein as **Exhibit B**. For clarification, an SGA can recommend an MGA, GA, Agent and Solicitor; and an MGA can recommend a GA, Agent, and Solicitor.

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

1.7 **Med Supp Plan** is a Medicare supplement insurance product authorized under applicable federal and state laws and regulations that may now or in the future be offered to individual beneficiaries by the Company.

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

- **Exhibit A** Agent Compensation Schedule
- **Exhibit B** Hierarchy Relationship Addendum
- **Exhibit C** Medicare Regulatory Addendum
- **Exhibit D** HIPAA Business Associate Addendum
- **Exhibit E** Branded Products Addendum

Executed this ____ day of _____, 20__.

AGENT CONTRACTING AS

**UNITED HEALTHCARE 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

Telephone Number: _____

Fax Number: _____

E-mail: _____

Tax I.D. Number: _____

Electronic Fund Transfer



SecureHorizons will deposit your check directly to your bank account. We make the deposit according to the current Commission Deposit Schedule. Below is an authorization form so that you may sign up for this service. Just complete the form and mail it back with your appointment paperwork.

Fund Transfer Authorization

I (We) do hereby authorize the deposit of all commission payments due me (us) to my (our) checking account indicated below and the Depository Financial Institution named below to credit the payment(s) to such account by SecureHorizons.

Account Number

Financial Institution Name

City

State

I (We) reserve the right to revoke and cancel this authorization. Such revocation and cancellation to take effect upon written notice received at the office of SecureHorizons with reasonable time to act on such notice.

Agent Signature

SIGN HERE

Agent Number (if known)

Date

John Doe
123 w. Main St.
Anytown, USA 12345

DATE _____

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PAY TO THE ORDER OF

ATTACH A BLANK VOIDED CHECK HERE
(Deposit slips are NOT acceptable)

DOLLARS

YOUR BANK
ANYTOWN, USA

FOR _____

VOID

⑆01010⑆0011 ⑆0551005115⑆ 401