

Check list for submitting paperwork for appointment

____ Prospective Broker Application, sign and date

____ Profile completed

____ Fair Act Reporting Disclosure, sign and date

____ Assignment of Commissions form if applies

(Applies if Commission is paid to an agency or the Key Broker)

Note: Make sure 1 of the 2 boxes on form is marked, commonly over looked

____ Credit Card Authorization form for fees if applies

Note: Make sure expiration date and security code is listed,

commonly over looked

____ Explanation page

Note: complete if any of the legal questions on the application are answered "yes".

____ License

____ Signature Page, sign and date

Fax all forms to 317-715-7375



PROSPECTIVE BROKER APPLICATION

A UnitedHealthcare Company

GRIC Manager/Representative CHERYL PICKETT FAX: 317-715-7375
Independent Broker Financial Services Company Name: F1E42 - Bradley Kerby

Complete Name I prefer to be called:

Name of Agency or Company

Business Street Address (Required for Supplies)

Business Mailing Address

City County State ZIP

Phone () Fax () E-mail

Home Address

City County State ZIP

Phone () Birth Date Gender

Social Security No. National Producer No.

Length of time in present community. If less than five years, please provide previous address(es).

Please check the appropriate box.

- All commissions are to be paid to me.
All commissions are to be paid to Agency, Company, or Name Tax ID No.

Please answer all questions. (If YES, include details of who, what, when, and dollar amounts on an additional form.)

- 1. Have you ever had an appointment terminated by any insurance company or financial services institution (for reasons other than production)?
2. Do you owe any debt or balance to any insurance company or financial services institution that has remained overdue for more than sixty (60) days?
3. Has any state or federal agency ever denied, suspended, revoked, or taken any action against any fiduciary license held or applied for by you, or have you ever voluntarily submitted to any sanction or surrendered any fiduciary license under threat of suspension or revocation of that license?
4. Has any state or federal self-regulatory body of any type (such as National Association of Securities Dealers) ever taken any disciplinary measures against you?
5. Have you ever had a claim filed against your Errors and Omissions Coverage, or has any bonding company ever denied, paid out on, or revoked a bond for you?
6. Have you ever been the subject of any civil or administrative proceeding, including one initiated by a state department of insurance?
7. Do you have any felony charges pending against you, or have you ever pled guilty or nolo contendere to or been convicted of a felony or a crime involving moral turpitude?
8. Do you have any unsatisfied liens (tax or otherwise) or judgments (civil or otherwise) against you?
9. Have you been the subject of a bankruptcy petition or proceeding in the past seven (7) years?

(1) I hereby represent that the answers and statements ("the information") I am giving Golden Rule Insurance Company and its affiliates ("the Company") on this application ("PBA") are correct, complete, and wholly true. (2) I understand the Company will rely on the information as one factor in considering this PBA, and may, at its option, terminate or rescind our resulting business relationship if any of the information is not as I have given it. (3) I give the Company, its employees, agents, and/or contractors permission to direct advertising or promotional phone calls, faxes, and electronic mail to the numbers and addresses I have listed above, as well as any others I provide. This permission continues until specifically revoked by me in writing. (4) I understand this PBA will not be considered until I sign the FCRA Authorization.

Signature Date

NOTE: No business may be solicited until all state licensing and appointment and/or contract requirements have been met, and you have been advised of that fact in writing by the Company.

FAIR CREDIT REPORTING ACT DISCLOSURE and AUTHORIZATION

GOLDEN RULE INSURANCE COMPANY AND ITS AFFILIATED COMPANIES ("THE COMPANY") MAY OBTAIN A CONSUMER REPORT ABOUT YOU IN CONNECTION WITH YOUR PROSPECTIVE BROKER APPLICATION ("PBA")

AUTHORIZATION

I authorize the Company to conduct a public records search, and/or to obtain a consumer report and/or investigative consumer report about me from a consumer reporting agency. These reports may concern my credit history, worthiness, standing, and/or capacity. These reports may also concern my character, general reputation, personal characteristics, mode of living, criminal history, motor vehicle record, and other data relevant to the appointment and/or contract process with the Company. I understand the Company will use this data within that process as one factor in considering my PBA.

I understand that if the Company decides not to approve my PBA, and thereby to take adverse action against me because of information contained in any consumer report(s) authorized by my signature on this form, the Company will provide to me:

- A written pre-adverse action disclosure;
- An adverse action notice;
- A copy of any consumer report(s) received and used by the Company;
- A copy of "A Summary of Your Rights Under the Fair Credit Reporting Act";
- The name, address, and telephone number of any consumer reporting agency that furnished a consumer report about me to them.

I understand that I am entitled to contest the accuracy or completeness of information contained in any consumer report. I understand that I am entitled to receive an additional free copy of any consumer report. I understand that the consumer reporting agency does not itself make any decision regarding my PBA, and the agency cannot explain the Company's decision to me.

A photocopy or fax copy of this authorization shall be as effective as the original. This authorization remains valid until I revoke it in writing sent to the Company.

Printed Name

Social Security Number

Signature

Date

Home Address

City, State, and ZIP

Golden Rule[®]

A UnitedHealthcare Company

ASSIGNMENT OF COMMISSIONS AND OTHER COMPENSATION

To: Golden Rule Insurance Company and/or American Medical Security Life Insurance Company and/or Pacificare Health Plan Administrators, Inc., and/or United Healthcare Insurance Company, and/or any affiliated company (collectively, "the Company")

I ("Assignor") hereby direct the Company to pay to my Assignee specified below all compensation due and payable to me under any compensation agreement(s) between myself and the Company ("the Contract"):

PLEASE PRINT _____
Assignee Name
Social Security/Tax ID Number

PLEASE PRINT _____
Street
City
State
ZIP
Phone

* This Assignment applies to (select **ONE**):

- all first year and renewal compensation; or
- all compensation attributable to my business written **after** the date this form is processed by the Company.

I understand and agree that:

1. Payments made by the Company pursuant to this Assignment fully discharge all of the Company's financial obligations to me under the Contract.
2. This Assignment is subject to, and does not affect, any terms or conditions of the Contract except as specifically provided herein.
3. This Assignment is subject to applicable state and federal laws regarding assignment of commissions by insurance producers (by whatever name called). The Company will not be bound by this Assignment in any instance in which it believes applicable law prevents it from paying the Assignee, and it then may pay the person or entity that it, in its sole discretion, determines to be appropriate under the circumstances.
4. This Assignment shall remain in effect, and is binding on both myself and the Company, until revoked. I may revoke this Assignment by sending written notice to the Company. Revocation will be effective on the latter of the date I request, or thirty (30) days after the Company's receipt of the notice. Otherwise, this Assignment is automatically revoked concurrently with termination of the Contract for cause, or upon commencement of any proceeding in bankruptcy, liquidation, receivership or dissolution by or against me or my listed Assignee.

Assignor Signature

Witness Signature

Assignor Printed Name

Witness Printed Name

Social Security/Tax ID Number

Street Address

City, State, Zip, Residence Phone Number

Date Signed

Date Signed

Sign and Return this Page to Golden Rule

**INDEPENDENT BROKER'S CONTRACT
SIGNATURE PAGE**

I acknowledge and agree that:

- (a) I have received a copy of the Independent Broker's Contract Form: (IBC-0405), consisting of this page and four (4) other pages, as well as the Rules and Regulations (Rules-0405), which are fully incorporated by reference and made a part of the *Contract*;
- (b) I have read, understood, and agreed to each and every term of this *Contract*; and
- (c) This *Contract* will not be in effect until such time as the *Company* has countersigned this Signature Page and attached the appropriate *Commission Schedule(s)*.

YOU: _____ **By:** _____
Print or type *Your Name* Print Name (and title if signing in a representative capacity)

Signature _____ Date _____

BENEFICIARY DESIGNATIONS (See 3.9): Name Address Relationship
Primary Beneficiary(ies):

Contingent Beneficiary(ies):

Producer Information

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**FOR HOME OFFICE USE ONLY
EXECUTED ON BEHALF OF GOLDEN RULE INSURANCE COMPANY**

BY: _____

Signature _____ Date _____

This agreement shall take effect as of _____ Producer No. _____

IBC-0405

1 How many new individual health applications did you personally write in the past 12 months with all companies combined -- excluding Short Term, Medicare Supplements, and Employer/Group policies? (Check one.)

0 1-3 4-7 8-11 12-20 21-50 51-100 101-200 201+

How many do you plan to write in the next year? (Check one.) More Same Less

2 What type of individual health plans do you personally write most often -- excluding Short Term, Medicare Supplements, and Employer/Group policies? (Check one.)

- Low Deductible Copay Plans** -- Plans with \$1,000 or lower deductible which include doctor office visit copays.
- High Deductible Copay Plans** -- Plans with \$1,250 or higher deductible which include doctor office visit copays.
- Traditional Major Medical Plans** -- Major medical plans that do not include doctor office visit copays.
- HSA Plans** -- Plans that combine medical insurance with a tax-favored savings account.
- Hospital Surgical Plans** -- Lower premium plans which primarily cover major hospital and surgical expenses.
- Other** -- Please specify. _____

3 Please put the number 1 by the company you consider to be your primary source for your new individual health applications and a number 2 by your secondary company. Please mark 1 and 2 only.

<input type="checkbox"/> Aetna	<input type="checkbox"/> Anthem Blue Cross/ Blue Shield	<input type="checkbox"/> Golden Rule	<input type="checkbox"/> Pacific Care
<input type="checkbox"/> American Community	<input type="checkbox"/> Celtic	<input type="checkbox"/> Humana	<input type="checkbox"/> Unicare
<input type="checkbox"/> American Medical Security	<input type="checkbox"/> Fortis/Time/Assurant	<input type="checkbox"/> John Alden	<input type="checkbox"/> None
<input type="checkbox"/> American Republic		<input type="checkbox"/> Medical Mutual	<input type="checkbox"/> Other _____

4 In the past 12 months, how many of the following products have you written?

Short Term Medical Plans	Medicare Supplements	Health Savings Accounts (HSAs)
<input type="checkbox"/> 0	<input type="checkbox"/> 0	<input type="checkbox"/> 0
<input type="checkbox"/> 1-10	<input type="checkbox"/> 1-10	<input type="checkbox"/> 1-10
<input type="checkbox"/> 11-50	<input type="checkbox"/> 11-50	<input type="checkbox"/> 11-50
<input type="checkbox"/> 51+	<input type="checkbox"/> 51+	<input type="checkbox"/> 51+

5 Which company's individual short-term medical plan(s) do you write? Please mark 1 and 2 only.

<input type="checkbox"/> American Community	<input type="checkbox"/> Celtic	<input type="checkbox"/> Healthnet	<input type="checkbox"/> None
<input type="checkbox"/> American Family	<input type="checkbox"/> Fortis/Time/Assurant	<input type="checkbox"/> Humana	<input type="checkbox"/> Other _____
<input type="checkbox"/> Anthem Blue Cross/ Blue Shield	<input type="checkbox"/> Golden Rule	<input type="checkbox"/> Trustmark	
	<input type="checkbox"/> GradMed		

6 Which company's Medicare supplement plan(s) do you write? Please mark 1 and 2 only.

<input type="checkbox"/> Anthem Blue Cross/ Blue Shield	<input type="checkbox"/> Continental Life	<input type="checkbox"/> Mutual of Omaha	<input type="checkbox"/> Unicare
	<input type="checkbox"/> Golden Rule	<input type="checkbox"/> Standard Life	<input type="checkbox"/> Other _____

Mar 20 2006 03:01:19 pm

To receive advanced commissions you must sign an electronic funds agreement so that your commissions will be deposited directly into your bank account.

Bank Name_____

Bank phone number_____

Bank Address_____

Bank City, State, Zip_____

Routing number_____

Account number_____

Your phone number_____

In the event that commissions are reversed from cancelled policies your account will be debited. Advanced commissions will be paid monthly.

Agreed to:

Signed_____ **Date**_____

