MAIL ENTIRE PACKAGE TO NEW AGENT PROCESSING, 5965 SANDY RIDGE, ELKRIDGE, MD 21075 WITH APPOINTMENT FEES AND LICENSES INCLUDED

A UnitedHealthcare Company

PROSPECTIVE BROKER APPLICATION

GRIC Manager/Representative ____________

❑ Independent Broker ❑ Financial Services ☑ Company Name: F3E73-Stephens-Matthews

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.)

	Question	YES	NO
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 authoriztion 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

34370-0306

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").

If and when the Company owes me compensation because I have sold or secured the sale of insurance products of the Company or for any other reason, I (the undersigned "Assignor") do not wish to receive that compensation, but instead assign all of the compensation to, and direct the Company to pay all of it to, the person or entity I have written below as Assignee:

PLEASE PRINT ____

Assignee Name (person/entity to be paid) 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 any compensation arrangement between us (individually or collectively 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. Such revocation will only apply to business written after the effective date of the revocation, and this Assignment will remain in effect for business written for the Company prior to that date. 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.

5. This Assignment does not apply to merchandise, trips or other non-cash incentives, awards, contests or other remuneration (collectively "prizes") that the Company may offer from time to time. It also does not apply to a cash equivalent in the event either I or the Company choose to remit or accept such cash equivalent in lieu any particular prize.

______________________ ______________________ ______________________

Assignor Signature Assignor Printed Name 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)

X ______________________________ ______________________________
Signature — Date

BENEFICIARY DESIGNATIONS (See 3.9): Name Address Relationship

Primary Beneficiary(ies):

____

____

Contingent Beneficiary(ies):

____

____

____

Producer Information

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

BY: ______________________________

X ______________________________
Signature — Date

This agreement shall take effect as of ______________ **Producer No.** ______________

Golden Rule®

A UnitedHealthcare Company

PROFILE INFORMATION

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.

___ Aetna	___ Anthem Blue Cross/ Blue Shield	___ Golden Rule	___ Pacific Care
___ American Community	___ Celtic	___ Humana	___ Unicare
___ American Medical Security	___ Fortis/Time/Assurant	___ John Alden	___ None
___ American Republic		___ Medical Mutual	___ 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)
❑ 0	❑ 0	❑ 0
❑ 1-10	❑ 1-10	❑ 1-10
❑ 11-50	❑ 11-50	❑ 11-50
❑ 51+	❑ 51+	❑ 51+

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

___ American Community	___ Celtic	___ Healthnet	___ None
___ American Family	___ Fortis/Time/Assurant	___ Humana	___ Other ________
___ Anthem Blue Cross/ Blue Shield	___ Golden Rule	___ Trustmark	
	___ GradMed		

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

___ Anthem Blue Cross/ Blue Shield	___ Continental Life	___ Mutual of Omaha	___ Unicare
	___ Golden Rule	___ Standard Life	___ Other ________

Mar 20 2006 03:01:19 pm

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Appointment Fee Credit Card Authorization Form

Producer's NPN (National Producer Number) (If known): ______________________

I authorize Golden Rule to bill my VISA/MASTERCARD account.

☐ VISA ☐ MASTERCARD Exp. Date:________/________ Amount Charged: ☐☐☐☐☐☐

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

X______________________________

Printed Name (Please print legibly)

____

Telephone Number *Required*

X______________________________

Signature of Cardholder

Payment is for: (Please check one)

☐ Appointment Fee

☐ Renewal Fee

☐ Charge Back

NOTE: Your resident appointment fee is refundable upon the submission of your first Golden Rule application.

State Resident and Nonresident Appointment Fees

If payment is for appointment fee(s), please indicate the state and fee(s) to be charged.

These fees are charged by each state's department of insurance and are subject to change.

State	Resident	Non-resident	State	Resident	Non-resident
Alabama	☐ $30	☐ $30	Missouri	☐ No Fee	☐ No Fee
Alaska	☐ No Fee	☐ No Fee	Montana	☐ No Fee	☐ No Fee
Arizona	☐ N/A	☐ N/A	Nebraska	☐ $8	☐ $8
Arkansas	☐ Fee Paid*	☐ Fee Paid*	New Hampshire	☐ $25/Agency $25	☐ $25/Agency $25
California	☐ $24/Agency $24	☐ $24/Agency $24	New Jersey	☐ $25/Agency $25	☐ $25/Agency $25
Colorado	☐ N/A	☐ N/A	New Mexico	☐ $23	☐ $23
Connecticut	☐ No Fee	☐ No Fee	Nevada	☐ $15/Agency $15	☐ $15/Agency $15
Delaware	☐ $25	☐ $25	North Carolina	☐ $20 + $10**	☐ $20 + $10**
District of Columbia	☐ $25/Agency $25	☐ $25/Agency $25	North Dakota	☐ $10/Agency $10	☐ $10/Agency $10
Florida	☐ $60	☐ $60***	Ohio	☐ $20/Agency $20	☐ $20/Agency $20
Georgia	☐ $10	☐ $10	Oklahoma	☐ $40/Agency $40	☐ $40/Agency $40
Hawaii	☐ No Fee	☐ No Fee	Oregon	☐ No Fee	☐ No Fee
Idaho	☐ No Fee	☐ No Fee	Pennsylvania	☐ $15/Agency $15	☐ $15/Agency $15
Illinois	☐ N/A	☐ N/A	Rhode Island	☐ N/A	☐ N/A
Indiana	☐ N/A	☐ N/A	South Carolina	☐ Fee Paid*	☐ Fee Paid*
Iowa	☐ No Fee	☐ No Fee	South Dakota	☐ $10/Agency $10	☐ $20/Agency $20
Kansas	☐ $5/Agency $5	☐ $5/Agency $5	Tennessee	☐ $15	☐ $15
Kentucky	☐ $40/Agency $100	☐ $50/Agency $120	Texas	☐ $10/Agency $10	☐ $10/Agency $10
Louisiana	☐ $20/Agency $20	☐ $20/Agency $20	Utah	☐ No Fee	☐ No Fee
Maine	☐ $30/Agency $30	☐ $70/Agency $70	Vermont	☐ $60	☐ $60
Maryland	☐ N/A	☐ N/A	Virginia	☐ $12/Agency $12	☐ $12/Agency $12
Massachusetts	☐ $75/Agency $75	☐ $75/Agency $75	Washington	☐ $20/Agency $20	☐ $20/Agency $20
Michigan	☐ $5/Agency $5	☐ $5/Agency $5	West Virginia	☐ $25	☐ $25
Minnesota	☐ $10	☐ $10	Wisconsin	☐ $7	☐ $24
Mississippi	☐ $10	☐ $10	Wyoming	☐ $15/Agency $15	☐ $15/Agency $15

* Fee paid by appointing insurance company.

** Add $10 for Med Supp/LTC appointment.

*** Add $6 per Florida county.

PBA Explanation Page

This page is required for any of the questions that have a "yes" answer on the Prospective Broker Application. A detailed explanation is needed and should include who was involved, when it occurred, dollar amounts, detailed information as why it occurred and steps taken to resolve issue.

Producer Name: ______________________

Producer number: ______________________

Question # ________

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_____________________________ Producer Signature

_____________________ Date