Integrated Benefits, Inc.

Appointment Instructions for

Care Improvement Plus

Please complete the following:

1. _______ **Producer Information Page**: Complete all required information.

2. _______ **Background Information**: Answer each question by marking the appropriate box. If you answer yes to any question please Provide an explanation.

3. _______ **W-9**: Complete and sign.

4. _______ **Commission Schedule**: Sign and Date

4. _______ **State License**: Please provide a copy of your resident state license and any non-resident licenses for the states you wish to be appointed in.

5. _______ **E&O:** Please provide a copy of your Errors and Omissions coverage.

6. _______ **Drivers License:** Please provide a copy of your drivers license.

Once all information has been completed you can fax the attached information to 304-342-4978 or mail it to the address below:

Integrated Benefits, Inc.
Attn: Sales Support
1510 Kanawha Blvd. E.
Charleston, WV 25311

If you have any questions please feel free to contact your Regional Marketing Director at 800-962-4693.

PRODUCER INFORMATION

Please Print
Producer Name (as it appears on your state license)

Name: ____
First MI Last Suffix

Date of Birth: ________________ Drivers License Number ____________________
(MM/DD/YYYY)

Social Security Number: _____-_____-______ Emial: ________________________

Resident State: _________ In which states do you want to be contracted:_______________

Present Home Address: ______________________________________
Street

____
City State Zip

Home Telephone: (_____) _______-__________ Home Fax: (_____) ______- _____________

Previous Home Address (If less than 24 months): ________________________________
Street

____
City State Zip

Business Address(if different than home address): ________________________________
Street

____
City State Zip

Business Telephone: (______) _____ - ________ Business Fax: (_____) ______-____________

Shipping Address (If different than business address):_____________________________
Street (No P.O. Boxes)

____
City State Zip

Please Identify if you will be contracting as a(n)? ☐ Individual-Sole Proprietor ☐ Corporation
☐ Limited Liability Company ☐ Limited Liability Partnership ☐ Partnership

Please provide Errors & Omissions Carrier Name: ______________________________

Please provide Errors & Omissions Policy #: __________________________________

Effective Date: __________________ Expiration Date: ______________________

I would like my commission check assigned to (not applicable for solicitors):
☐ Myself ☐ My Agency ☐ My G.A.

If you Coose Agency or G.A., Please provide the Corporate/Partnership:

Name:_______________________________ Tax ID#: ____________________

Background Information

1. Have you ever had your insurance license surrendered or revoked? ☐ Yes ☐ No

   If yes, please explain: ____

2. Is your insurance license currently restricted or under investigation? ☐ Yes ☐ No

   If yes, please explain: ____

3. Have you ever been refused a surety bond or had a claim paid for your? ☐ Yes ☐ No

   If yes, please explain: ____

4. Have you ever filed for bankruptcy? ☐ Yes ☐ No

   If yes, please explain: ____

5. Have you ever been convicted of a felony or misdemeanor, excluding traffic violations? ☐ Yes ☐ No

   If yes, please explain: ____

6. Are you at present involved in any litigation or administrative proceeding related to the insurance business or are there unsatisfied judgements against you? ☐ Yes ☐ No

   If yes, please explain: ____

7. Have you ever been listed as debarred, excluded or otherwise ineligible for participation in federal health care program? ☐ Yes ☐ No

   If yes, please explain: ____

Recruitment Information:

Identify Who Recruited You: ____

Broker Name or Agency Name: ____

Tax ID Number: ____________________

Form **W-9**
(Rev. November 2005)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type
See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ▶ ------------------ ☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

or

Employer identification number

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

Sign Here **Signature of U.S. person ▶** **Date ▶**

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

In 3 above, if applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

For federal tax purposes, you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

AGENT 4 SCHEDULE A

MEDICARE ADVANTAGE COMMISSION SCHEDULE

The commission for each Individual enrolled as a Medicare Enrollee by Broker is as follows:

- **First year company generated lead**

  - $230 per enrollment
  - Paid out in one lump sum within 30 days of Integrated Benefits, Inc. receiving payment from Care Improvement Plus.
  - Broker will be charged back the full amount if member disenrolls in the first 90 days of being on the plan unless it is due to death or permanent move out of the service area.
  - Will pay only once for each member (if member disenrolls then reenrolls a 2nd commission will not be paid)

- **First year Agent generated lead**
  - $330 per enrollment
  - Paid out in one lump sum within 30 days of Integrated Benefits, Inc. receiving payment from Care Improvement Plus.
  - Broker will be charged back the full amount if member disenrolls in the first 90 days of being on the plan unless it is due to death or permanent move out of the service area.
  - Will pay only once for each member (if member disenrolls then reenrolls a 2nd commission will not be paid)

- **Retention Program**.

- The incentive structure described in this section is for the second through fifth years of membership with Care Improvement Plus.

- **Second and Third year**

  - A payment of 50% of the first year's commission will be paid to Broker per member that is on the plan.
  - Paid out in one lump sum ($165 per payout for broker generated member and $115 per payout for company generated member) within 30 days of Integrated Benefits, Inc. receiving payment from Care Improvement Plus for years two (2) and three (3) as long as the member is on the plan
  - If member disenrolls for any reason prior to anniversary date NO payment will be made
  - Will pay only once for each member (if member disenrolls then reenrolls a 2nd commission will not be paid)

- **Fourth and Fifth year**

  - A payment of 50% of the second (2) and third (3) year's commission will be paid to Broker per member that is on the plan.
  - Paid out in one lump sum ($82.50 per payout for broker generated member and $57.50 per payout for company generated member) within 30 days of Integrated Benefits, Inc. receiving payment from Care Improvement Plus for years four (4) and five (5) as long as the member is on the plan
  - If member disenrolls for any reason prior to anniversary date NO payment will be made
  - Will pay only once for each member (if member disenrolls then reenrolls a 2nd commission will not be paid)

Based on payment received from Care Improvement Plus, Integrated Benefits, Inc. shall calculate on a monthly basis the total amount due Broker for Individuals enrolled as Medicare Enrollees according to CMS' records, and pay such total amount on or before the 15th day of the following month.

Broker further understands and agrees that Integrated Benefits, Inc. shall charge back to Broker payments made to Broker for any Individual enrolled by Broker as a Medicare Enrollee in the event of a rapid disenrollment (within three (3) months of the effective date as a Medicare Enrollee) of such Individual. Any charge back shall be applied against any future amounts Integrated Benefits, Inc. may owe Broker with respect to any of the Products. Charge back will not occur if the rapid disenrollment is due to death or permanent move out of the Service Area.

In addition to the foregoing, Integrated Benefits, Inc. may adjust or offset Broker's compensation to recoup payments made on behalf of a Medicare Enrollee for whom CMS has disenrolled or has determined to be ineligible and has made a retroactive adjustment to Integrated Benefits, Inc.'s payments. Retroactive adjustments to Broker's payments shall be for the same period covered by the retroactive adjustments to Integrated Benefits, Inc.'s payments by CMS. Broker shall have no claim to commissions except as provided herein.

Agent Name:______________________________________

Signature:____

Date:______________