Visionary Insurance Partners
VIP Products & Service

Golden Rule®
A UnitedHealthcare Company

Golden Rule Contracting

Please complete the following pages and send it back to Visionary Insurance.
Be sure to include:

- All pages of contracting documents
- EFT
- W9

Once completed, please send to Lura @ VIP:

Email to: lura@vipagents.net

OR

Fax to: 610.779.3605

Please contact Lura with any questions at 484.772.4723 or via email lura@vipagents.net

Check out our website www.vipagents.net

UnitedHealthOne

PROSPECTIVE PRODUCER APPLICATION

UHCLIC Manager/Representative **MARIAH VANCE**

☐ Independent Producer _____

☐ SubProducer of Key/FMO STEPHENS MATTHEWS

Key/FMO No.**AA1499597**

Full Legal Name _____ I prefer to be called: _____

Business Street Address (Required for Supplies) _____

Business Mailing Address _____

City _____ County _____ State _____ ZIP_____

Business Phone (____) _____ Fax (____)_____

E-mail _____

Home Address _____

City _____ County _____ State _____ ZIP _____

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

	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 Assn. 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 UnitedHealthcare Life Insurance Company and its affiliates ("the Company") on this application ("PPA") are correct, complete, and wholly true. **(2)** I understand the Company will rely on the information as one factor in considering this PPA, 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 listed above, as well as any others I provide. This permission continues until specifically revoked by me in writing. **(4)** I understand this PPA will not be considered until I sign the FCRA Authorization.

Signature X _____ **Date** _____

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

DISCLOSURE

UNITEDHEALTHCARE LIFE INSURANCE COMPANY AND/OR ANY AFFILIATED COMPANY (COLLECTIVELY, "THE COMPANY") MAY OBTAIN CONSUMER REPORTS AND/OR INVESTIGATIVE CONSUMER REPORTS ABOUT YOU IN CONNECTION WITH YOUR CONTRACT REQUEST, AS WELL AS ANY SUBSEQUENT REQUESTS.

AUTHORIZATION

I authorize The Company to conduct a public records search, and/or to obtain a consumer reports, and/or an investigative consumer reports 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, criminal, and civil history, and/or mode of living. I understand that The Company will use this information in whole or in part as a factor in considering my initial contract or any subsequent changes in my relationship with The Company.

I understand that if The Company decides not to approve my contract/request 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"; and
- 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 request with The Company, 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 permission continues until specifically revoked in writing by the person who signs below.

Printed Name _____ **Social Security Number** _____

Signature _____ **Date** _____

Address _____

City _____ **State** _____ **ZIP Code** _____

UnitedHealthOne

PROFILE INFORMATION

1. Over the past 12 months, what percentage of total revenue from your current insurance business does individual health represent? (Check one.)

❑ 0%-10% ❑ 11%-24 ❑ 25%-49% ❑ 50% or more

2. What type of insurance is your primary line of business? (Check one.)

❑ Annuities/LTC
❑ Disability Income Insurance
❑ Financial Services
❑ Group Health
❑ Individual Health
❑ Life
❑ Medicare Business (Part D, Supplement, etc.)
❑ Property/Casualty
❑ Supplemental Policies (Accident, Dental, Vision)
❑ Other

3. How many new individual health applications did you personally write in the past 12 months with all carriers combined—excluding Short Term, Medicare Plans, Employer, and Employer/Group policies? (Check One.)

❑ 0
❑ 1-5
❑ 6-10
❑ 11-2
❑ 21-50
❑ 51-100
❑ 101-200
❑ 201+

4. How many do you plan to write over the next 12 months? (Check one.)

❑ More
❑ Same
❑ Less

5. Which of the following carriers do you consider to be the primary and secondary recipients of your new individual health applications? Please mark your primary carrier with the number 1, and your secondary carrier with the number 2. Please mark 1 and 2 ONLY.

___Aetna
___American Community
___American Medical Security
___Assurant/Fortis/Time
___Blue Cross Blue Shield/ Anthem/Wellpoint
___Celtic
___Cigna
___Coventry/Health America
___Golden Rule/UnitedHealth One/UnitedHealthcare
___Health Net
___Humana One
___Kaiser Permanente
___Mega Life and Health
___Medical Mutual
___PacifiCare
___World Insurance
___Unicare
___None
___Other _____

6. Over the past 12 months, how many of the following products have you personally written?

Short Term Medical Plans
- ❑ 0
- ❑ 1-9
- ❑ 10-24
- ❑ 25+

Medicare Plans (Supplements, Advantage Plans or Part D)
- ❑ 0
- ❑ 1-9
- ❑ 10-24
- ❑ 25+

Health Savings Accounts (HSAs)
- ❑ 0
- ❑ 1-9
- ❑ 10-24
- ❑ 25+

Dental (standalone) Insurance Plans
- ❑ 0
- ❑ 1-9
- ❑ 10-24
- ❑ 25+

Accident (standalone) Insurance Plans
- ❑ 0
- ❑ 1-9
- ❑ 10-24
- ❑ 25+

Critical Illness (standalone) Insurance Plans
- ❑ 0
- ❑ 1-9
- ❑ 10-24
- ❑ 25+

7. How many states are you licensed in for health insurance?
- ❑ 1
- ❑ 2-4
- ❑ 5-9
- ❑ 10 or more

ASSIGNMENT OF COMMISSIONS AND OTHER MONETARY COMPENSATION

To: UnitedHealthcare Life Insurance Company and/or Golden Rule Insurance Company and/or UnitedHealthcare Insurance Company, and/or All Savers 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 it to, and direct the Company to pay it to, the person or entity I have written below as Assignee per my applicability instructions below:

PLEASE PRINT STEPHENS-MATTHEWS MRKTG INC 31-1603665
Assignee Name (person/entity to be paid) Social Security/tax ID Number

PLEASE PRINT _____
Street City State ZIP Phone

This Assignment applies to (select and complete **option 1 OR 2** below):

1. X **All monetary compensation including commissions, monetary bonuses, monetary incentives/prizes.**
(in addition, check one box below)
X all monetary compensation attributable to my business written ***after*** the date this form is processed by the Company
OR
□ all monetary compensation for all business issued, including any business issued prior to this date (only allowed if no prior Assignment has been submitted by the Assignor to the Company)

2. □ **Commissions only (monetary bonuses and monetary incentives/prizes will be paid directly to you)**
(in addition, check one box below)
□ all commissions attributable to my business written ***after*** the date this form is processed by the Company
OR
□ all first year and renewal commissions for all business issued, including any business issued prior to this date (only allowed if no prior Assignment has been submitted by the Assignor to 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.

2. This Assignment is subject to, and does not affect, any terms or conditions of any such compensation arrangements 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 later of the date I request, or not later than thirty (30) days after the Company's receipt of the notice.

5. This Assignment does not apply to non-monetary incentives/prizes (e.g., merchandise, trips, non-cash incentives, awards, contest results, or any other non-cash remuneration).

6. Assignor understands the Assignee may enter into a Commission Advance Agreement ("Advance Agreement") with the Company. The Advance Agreement entitles the Assignee to receive an advance on the payment of compensation for business issued by the Company after the effective date of the Advance Agreement. Assignor understands and acknowledges that the Company, as a condition to agreeing to the Advance Agreement, requires the Assignee to obtain Assignments from all sub-brokers, including the Assignor. Assignor further agrees that commissions attributable to any business written by the Assignor that are advanced to the Assignee under their Advance Agreement are hereby assigned to the Assignor, even if the business was written prior to the date of this Assignment.

_____ _____
Assignor Signature Date Signed

_____ _____
Assignor Printed Name Social Security/Tax ID Number

PPA Explanation Page

This page is required for any of the questions that have a "yes" answer on the Prospective Producer 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 # _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Producer Signature Date

-SIGN AND RETURN THIS SIGNATURE PAGE-

INDEPENDENT PRODUCER'S CONTRACT
SIGNATURE PAGE

I acknowledge and agree that:

(a) I have received a copy of the Independent Producer Contract (IPC-1213),

(b) I have read, understood, and agreed to each and every term of the Contract, any and all provisions of which provisions of which cannot be altered without the express written consent of UnitedHealthcare Life; and

(c) This Contract will not be in effect until such time as UnitedHealthcare Life has countersigned this Signature Page.

(d) The Contract may be executed in two or more counterparts, any of which need not contain the signature of more than one party, but all such counterparts when taken together will constitute one and the same agreement.

YOU: _____
Print or type your name

X _____
Your signature Date:

Appointment Fee Form

For your privacy and protection credit card payments may only be accepted by telephone.
Please provide contact details so that we may call and obtain your authorization for credit card payment.

Contact Name: _____ *(required)* **Telephone Number:** _____ *(required)*

Producer Name: _____ **National Producer Number:** _____

NOTE: Your initial resident appointment fee is refundable upon the submission of your first 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.

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 ☐ Agency $30	☐ $30 ☐ Agency $30	Missouri	☐ N/A	☐ N/A
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	☐ N/A	☐ N/A
Connecticut	☐ No Fee	☐ No Fee	Nevada	☐ $15 ☐ Agency $15	☐ $15 ☐ Agency $15
Delaware	☐ $25	☐ $25	North Carolina	☐ $10 L + $10 H = $20	☐ $10 L + $10 H = $20
District of Columbia	☐ $25 ☐ Agency $25	☐ $25 ☐ Agency $25	North Dakota	☐ $10 ☐ Agency $10	☐ $10 ☐ Agency $10
Florida	☐ $60	☐ $60**	Ohio	☐ $20 L + $20 H = $40 ☐ Agency $20 L+$20 = $40	☐ $20 L + $20 H = $40 ☐ Agency $ L+$20 = $40
Georgia	☐ $10	☐ $10	Oklahoma	☐ $30 ☐ Agency $30	☐ $30 ☐ Agency $30
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	☐ $10 ☐ Agency $10	☐ $10 ☐ Agency $10
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	☐ $30	☐ $30	Wisconsin	☐ $16	☐ $50
Mississippi	☐ $25	☐ $25	Wyoming	☐ $15 ☐ Agency $15	☐ $15 ☐ Agency $15

* Fee paid by appointing insurance company.
** Add $6 per Florida county.

Not For consumer Use

STEPHENS-MATTHEWS MARKETING, INC.

■PO Box 1208 ■ Beverly, OH 45715 ■ Phone: (800) 544-8250 ■ Fax: (888) 984-2614 ■

Return by fax to: 888-984-2614 or email to: Kelly@stephens-matthews.com

Agent Commission Electronic Funds Transfer Form

Agent/Agency Name: _____

Daytime Phone Number: _____

Email Address: _____

Account Type (Please Check One): ☐ Checking Account (22) ☐ Savings Account (32)

If you are authorizing electronic fund transfer either for the first time or to a different account:

1. For checking account, please void a **pre-printed blank check** and attach here.
2. For savings account, please void a **pre-printed deposit slip** and attach here.

We cannot accept voided checks or deposit slips with a handwritten name and address.

3. Please transfer the numbers at the bottom of the check or deposit slip into the fields below.

___ ___ ___ ___ ___ ___ ___ ___ ___
Bank Routing Number

_____
Bank Account Number

Authorization

I hereby authorize Stephens-Matthews Marketing, Inc. to initiate credit entries and, if necessary, adjustments for any credit entries made in error to the checking or savings account indicated above, hereinafter called depository.

Agent Signature: _____

Please submit an updated authorization any time you change depositories.

Agents receiving Electronic Funds will receive commission statements via e-mail only.

Form **W-9**
(Rev. December 2011)
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/disregarded entity name, if different from above

Check appropriate box for federal tax classification:
☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶

☐ Other (see instructions) ▶

☐ Exempt payee

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 the "Name" line 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

			–		–				

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. citizen or other U.S. person (defined below).

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 ▶**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

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.

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. 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.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

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.