



# PRODUCERS APPOINTMENT FORM

Agent Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security# \_\_\_\_\_  
 Corporation/Agency Name \_\_\_\_\_ Tax I.D. \* \_\_\_\_\_ Email \_\_\_\_\_  
 Business Street Address \_\_\_\_\_ City \_\_\_\_\_ St. \_\_\_\_\_ Zip \_\_\_\_\_  
 Resident Street Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_  
 Business Telephone # ( \_\_\_\_\_ ) \_\_\_\_\_ Fax # ( \_\_\_\_\_ ) \_\_\_\_\_ Resident Telephone # ( \_\_\_\_\_ ) \_\_\_\_\_

\* If we are to pay commissions to an Agency or Corporation, and you are not the Owner / Officer, we need an assignment of commissions signed by you and we must have another License Request Form completed by the Agency Owner / Officer; and copies of their license. Include the Agency's license if applicable in your state.

### COMMISSION ASSIGNMENT FORM \*

(Only complete the following if you want HPA to pay your commissions to a Corporation, Agency or another Agent.)

I \_\_\_\_\_ (HPA Code #) \_\_\_\_\_  
 hereby assign to assignee, \_\_\_\_\_, all of my right, title, and interest in commissions and/or renewals to which I am now entitled or become entitled, under existing contracts and agreements, heretofore entered into by and between myself and Health Plan Administrators, Inc. I hereby authorize and empower Health Plan Administrators Inc., to pay assignee all commissions and renewals now due or which may accrue under said contracts, for a period of one year from this date and thereafter until such time as I terminate this assignment by written notice to Health Plan Administrators, Inc. I agree that such payments of commissions under my contract, the same as if payment was made directly to me. I hereby covenant and agree that I am the absolute and sole owner of said commissions, free from prior assignment or any encumbrance of any kind or character whatsoever, and that I have full right and lawful authority to sell and transfer the same as aforesaid.

Witness my hand this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, Agent's Signature \_\_\_\_\_

*CAUTION:* The person assigning his or her commissions (assignor) will not recover the right to receive any further commissions during the one year period from the date of this assignment unless and until the person to whom such rights are assigned (assignee) releases, in writing, his or her rights to receive such commissions. Please be certain you understand this before signing the form. This instrument may be revoked, in writing, by the Assignor at any time after the one year period. Address of

Assignee \_\_\_\_\_  
 Tax I.D.# \_\_\_\_\_ Assignee's HPA Code # \_\_\_\_\_

**Are you currently appointed with any of the following carriers?** Standard Security Life Insurance Company of New York .....  YES  NO  
 Madison National Life Insurance Company Inc. ....  YES  NO  
 American Insurance Company .....  YES  NO

### ANSWER THE FOLLOWING QUESTIONS

1. Have you ever been convicted of a felony? .....  YES  NO
2. Do you owe any unpaid balance to any Insurance Company, General Agent or Manager? .....  YES  NO
3. Have you ever been involved in an investigation with any State Insurance Department? .....  YES  NO
4. Has your license ever been suspended, cancelled or revoked by any State Insurance Department? .....  YES  NO
5. Have you ever had your appointment terminated by another insurance company for any reason other than lack of production? .....  YES  NO
6. Have you ever been charged arrested or convicted of a misdemeanor other than minor traffic violations? .....  YES  NO
7. Have you ever filed Bankruptcy, been sued or had a judgment entered against you? .....  YES  NO
8. Have you ever been refused a bond or had a bond cancelled for cause by any company? .....  YES  NO

9. What lines of insurance are you licensed:  Life  Accident / Health  Other \_\_\_\_\_

10. Resident License State \_\_\_\_\_ License # \_\_\_\_\_; Please circle any nonresident states where you hold a license and intend to market:  
**AK AL AR AZ CA CO CT DC DE FL GA HI IA ID IL IN KS KY LA MA MD ME MI MN MO MS MT  
 NC ND NE NH NJ NM NV NY OH OK OR PA RI SC SD TN TX UT VA VT WA WI WV WY**

**Please attach copies of all licenses noted above.**

\* By signing below I am giving HPA prior written express invitation and permission to transmit facsimile and email advertisements to me. \* The agent has no authority to act on behalf of the Insurance Company, bind insurance coverage, waive or alter any provision of the insurance application or the Policy under which a certificate of insurance is issued. \* No advertising material (on paper, over the radio or television or on the Internet) being the product's, HPA or the Insurance company's name or describing any named product administered by HPA can be produced without prior written approval from HPA and the insurance company.

### READ CAREFULLY BEFORE SIGNING

**NOTIFICATION:** As part of our normal procedure, an investigative report may need to be prepared. Some states require the appointing firm to do background checks on the agents they are appointing. The investigative report usually concerns information on an applicant's character, general reputation, personal characteristics, finances and mode of living. Investigations will be completed as states require. Appointments will be processed once the background investigation is complete. Your signature below acknowledges your understanding of this procedure. If you intentionally misrepresent any fact required on this application, it will be cause for refusal or revocation of the right to represent any or all of the above noted carriers. A copy of this authorization is as valid as the original.

Agent Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Title: \_\_\_\_\_  
 GA Name: \_\_\_\_\_ HPA Code#: \_\_\_\_\_ Email: \_\_\_\_\_  
 MGA NAME: \_\_\_\_\_ HPA Code#: \_\_\_\_\_ Email: \_\_\_\_\_  
 Address: \_\_\_\_\_ Tele: \_\_\_\_\_ Fax: \_\_\_\_\_

**Mail all completed forms with copies of your current license(s) to HPA or fax them to: 1-813-963-5570  
 HPA, Inc., P.O. Box 340869 Tampa, Florida 33694-0869**



**AGENT HEALTH ADDENDUM TO PRODUCER AGREEMENT**

This Addendum to the Producer Agreement identifies (1) the line of business for which Producer is appointed and authorized to solicit and procure applications; and (2) the commission schedule applicable to such line of business. HPA and Producer each agrees that this Addendum is subject to all of the terms and conditions of the Producer Agreement and shall be made part of and attached thereto.

**Payor:** Standard Security Life Insurance Company of New York

**Lines of Business:** Health & Dental

*Schedule of Base Commissions Addendum:*

<b>SHORT TERM MEDICAL<sup>1</sup></b> Earned Medical Premium	<b>STM LITE MEDICAL<sup>2</sup></b> Earned Medical Premium	<b>SECURE 12 X 3<sup>3</sup></b>		<b>SECURE DentalOne<sup>4</sup></b>	
18%	15%	1st Year	18%	1st Year	12%
		2 <sup>nd</sup> and 3 <sup>rd</sup> Year	9%	Renewal	9%

<sup>1</sup> SHORT TERM MEDICAL insurance commissions are calculated using the SHORT TERM MEDICAL Premium Rate for the policy at the time of issue. The SHORT TERM MEDICAL premium does not include administration or enrollment fees.

<sup>2</sup> STM LITE MEDICAL insurance commissions are calculated using the STM LITE MEDICAL Premium Rate for the policy at the time of issue. The STM LITE MEDICAL premium does not include administration or enrollment fees

<sup>3</sup> 2<sup>nd</sup> and 3<sup>rd</sup> year commissions are based on reapply premium calculated at time of reapply. The 12 X 3 premium calculation does not include administration or enrollment fees

<sup>4</sup> The commissionable premium calculation for SECURE DentalOne does not include OrthoCare fees, administration or enrollment fees

**To be attached to and made part of your Producer's Appointment Form with Health Plan Administrators**

**To Be Completed By Producer:**

**I direct my compensation to be made payable as indicated on the attached Producers Appointment Form.**

SSN #: \_\_\_\_\_

Agency/Company Name: \_\_\_\_\_

Print Agent Name: \_\_\_\_\_

Agent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

GA Agency/Name: \_\_\_\_\_ GA HPA#: \_\_\_\_\_

MGA Agency/Name: \_\_\_\_\_ MGA HPA#: \_\_\_\_\_



**AGENT HEALTH ADDENDUM TO PRODUCER AGREEMENT**

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**Payor:** United States Fire Insurance Company

**Line of Business:** Health

*Schedule of Base Commissions Addendum:*

<b>OVERSEAS TRAVEL MEDICAL<sup>1</sup></b>
15%

<sup>1</sup>Overseas Travel Medical commission calculations do not include administration or enrollment fees.

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**To Be Completed By Producer:**

**I direct my compensation to be made payable as indicated on the attached Producers Appointment Form.**

SSN #: \_\_\_\_\_

Agency/Company Name: \_\_\_\_\_

Print Agent Name: \_\_\_\_\_

Agent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

GA Agency/Name: \_\_\_\_\_ GA HPA#: \_\_\_\_\_

MGA Agency/Name: \_\_\_\_\_ MGA HPA#: \_\_\_\_\_

HPA Agt Adden 11-07



**AGENT HEALTH ADDENDUM TO PRODUCER AGREEMENT**

This Addendum to the Producer Agreement identifies (1) the line of business for which Producer is appointed and authorized to solicit and procure applications; and (2) the commission schedule applicable to such line of business. HPA and Producer each agree that this Addendum is subject to all of the terms and conditions of the Producer Agreement and shall be made part of and attached thereto.

**Product:** RX Pay Card

**Line of Business:** Discount RX

*Schedule of Base Commissions Addendum:*

<u>RX Pay Card</u>
15%

RX Pay Card commission calculations do not include administration or enrollment fees.

**To be attached to and made part of your Producer's Appointment Form with Health Plan Administrators**

**To Be Completed By Producer:**

**I direct my compensation to be made payable as indicated on the attached Producers Appointment Form.**

SSN #: \_\_\_\_\_

Agency/Company Name: \_\_\_\_\_

Print Agent Name: \_\_\_\_\_

Agent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

GA Agency/Name: \_\_\_\_\_ GA HPA#: \_\_\_\_\_

MGA Agency/Name: \_\_\_\_\_ MGA HPA#: \_\_\_\_\_

HPA Agt Adden 11-07