



National Insurance Benefit Coordinators, Inc.

Appointment Instructions for

United Healthcare / Care Improvement Plus

Please complete the following:

1. _____ **Appointment Application:** Completed, signed and dated by producer
2. _____ **Agent Agreement:** Completed, signed and dated by producer
3. _____ **EFT Form:** Completed, signed, attach voided check and dated by producer
4. _____ **State License:** Please provide a copy of your resident/non-resident state license(s)
5. _____ **W-9:** Completed, signed and dated by producer
6. _____ **E&O:** Please provide a copy of your current E&O Certificate.
7. _____ **CMS or AHIP:** Please provide a copy of your CMS or AHIP certification

Once all information has been completed you can fax the attached information to 501-372-2221 or e-mail to karen@nibconline.com.

If you have any questions please call us at 501-372-4800 or 800-880-1230.

National Insurance Benefit Coordinators, Inc.

112 Smart House Way
North Little Rock, AR 72114
(501) 372-4800 (800) 880-1230phone
(501) 372-2221 fax
www.nibconline.com



Contract and Certification Process for UnitedHealthCare

Thank you for your interest in UnitedHealthCare.

First, submit your contract to NIBC.

After NIBC submits your contract to UnitedHealthCare and your demographic information is entered into their producer database, their system automatically generates a Party ID number. A letter containing this Party ID number and full instructions is sent to NIBC, and we immediately forward it to you via e-mail.

Upon receiving your Party ID number, your next step would be to go to www.unitedhealthproducers.com. Register by clicking on the "Register Now" button located on the lower central portion of the welcome page. Click where it says "more".

You will need the following information to register:

Party ID AND
Social Security Number OR Tax Identification Number
AND Zip Code (your mailing preference as designated on your Appointment Application)

Once you are registered, you can access the training located in the Learning Center.

*******PARTY ID NUMBERS ARE USED FOR CERTIFICATION PURPOSES ONLY.*******

You must complete the basic certifications, as well as certification for at least one product, before UnitedHealthCare will generate your permanent writing number to complete the appointment process.

You will receive a welcome letter from UnitedHealthCare after successfully completing the background check, license review and appointment process. This letter will include your Writing Number. ***Your Writing Number will be used on all applications and correspondence with UnitedHealthCare from that point on.***

Once your writing number is received, you will need to re-register on UnitedHealthProducers with this new number. You will be able to take courses to obtain additional product certifications, obtain sales materials, track member applications, access information on how to use iEnroll to electronically submit enrollment applications, view your commission payments and much more!

For contracting questions, contact Karen Frisbee at 800-880-1230.

Good Luck and Happy Selling!

National Insurance Benefit Coordinators, Inc.

112 Smart House Way
North Little Rock, AR 72114
(501) 372-4800 (800) 880-1230 phone
(501) 372-2221 fax
www.nibconline.com

Appointment Application

UnitedHealthcare Insurance Company and Affiliates



THIS IS A WRITABLE FORM*

Please Print or Type: All fields must be complete and legible

Individual Information (All Individual Information fields required for all Appointment Applications).

Legal Name (As name appears on Individual Resident State Insurance License)

Last: Middle First:

Social Security Number Birth Date (MM/DD/YYYY) Alias/Other Names:

Resident Address

City State County (FL Only) Zip Code

Resident Phone Number Business Phone Number Fax Number

Email Address

Appointment Type: Individual OR Corporation *This must match information provided on the Agreement and W-9.*

Mailing Preference: Residential OR Business *If applying as an individual, but prefer mail be delivered to your business, fill in the Business Address section below.*

If Applying as a Corporation, the following information is also required. (You must be a Principal of the Corporation to Apply).

Corporation Name Principal

Corporate Tax ID Business Phone

Business Address

City State County Zip

Errors and Omissions Attestation of Coverage (\$1,000,000 per occurrence or 1,000,000 annual aggregate required)

Name of Carrier Policy #

By signing this attestation I am agreeing that I have met, and will maintain, the required Errors and Omissions coverage during my contract with UnitedHealthcare. I understand that failure to have met and maintained the Errors and Omissions coverage requirements will result in immediate termination.

Applicant's Signature: _____

SIGNATURE

Please appoint me in the following states:

NOTE: Failure to accurately and honestly answer any of the following questions may result in a declination of your application and appointment with UnitedHealthcare
If you answer "Yes" to any of these questions, please provide supporting documentation and a brief explanation on the next page of this form.

Criminal Background Information

- 1. Have you ever been convicted of a felony? Yes No
- 2. Have you ever been convicted of a misdemeanor (other than traffic) including an alcohol or drug-related offense? Yes No
- 3. Have you had your driver's license revoked within the past three years? Yes No

Department of Insurance and CMS

- 4. Have you ever had your insurance or securities license revoked and/or suspended by any department of insurance (even if later reinstated) for any reason?..... Yes No
- 5. Have you ever had a complaint reported against you (even if dismissed) by a consumer and/or insurance company for any reason with any department of insurance, FINRA, or other regulatory reporting agency including CMS?..... Yes No
- 6. Have you ever paid a fine related to a consumer complaint, failure to renew your license or continuing education credit in excess of \$500?..... Yes No
- 7. Have you ever been excluded, or are you aware of actions that could result in an exclusion, by the Office of Inspector General from participation in a government health care program, including Medicare and Medicaid?..... Yes No

Credit History

- 8. Have you filed for bankruptcy and/or had a bankruptcy discharged within the last five years? Yes No
- 9. Are you, at the present time, or have you been within the past five years, involved in any civil litigation, judgements, liens or foreclosures?..... Yes No
- 10. Are you, at the present time, or have you been within the past five years, reported as delinquent on state or federal taxes?..... Yes No

Other Companies

- 11. Do you owe any insurance company, marketing organization or individual for any premiums collected or monies advanced?..... Yes No
- 12. Have you ever been denied an appointment with any insurance company? Yes No
- 13. Have you ever been terminated for cause by any insurance carrier? Yes No
- 14. Have you been denied a bond or application for errors and omissions (E&O) coverage with any company Yes No

Other

- 15. Do you have other information related to criminal, insurance-related complaints, credit, etc., that was not covered by these questions that you wish to disclose?..... Yes No

Please provide an explanation for any "Yes" answers on the previous page in the corresponding sections below.

Criminal Background Information

Department of Insurance and CMS

Credit History

Other Companies

Other

Conditions and Agreements

I have thoroughly reviewed this application and have answered all questions to the best of my knowledge. By signing below, I hereby attest to all matters set forth above and agree to all matters set forth below.

I hereby agree that if and when any or all of the companies issue to me any Agreement(s) for which I hereby apply, I will be bound by such Agreement(s). I understand that my supervising office has specimen forms of the Agreement(s) on file and I have had the opportunity to review such Agreement(s). Submitting to the Company any application for insurance products, including but not limited to Medicare Advantage and Prescription Drug Plan, shall constitute my agreement to such Agreement(s) and all the terms, conditions and provisions set for therein.

I Acknowledge that by signing this Appointment Application and submitting any such insurance application for Insured Product, I have so agreed to the Agreement(s) and no future signature by me shall be necessary.

Disclosure

I have executed this Appointment Application as evidence of the understanding and acceptance of, and consent to its terms, and I agree that I will not solicit business until I receive notification from the Company that this acknowledgement has been approved and I have satisfied all the of certification requirements of the products I intend to sell.

I understand that as part of its approval process and throughout the term of my appointment with the Company, the Company may obtain an investigation consumer report to confirm information regarding my character, general reputation, credit history, personal characteristics, mode of living, criminal history, insurance licensing history, Office or Inspector General records and General Service Administrator excluded party records. I hereby authorize the Company to obtain such a report at any time after receipt of this Appointment Application and throughout the term of my appointment with the Company. The scope of this authorization is all-encompassing, allowing the Company to obtain from any outside organization all manner of investigative consumer reports now and throughout my appointment to the extent permitted by law.

I understand that failure to accurately and honestly respond to any of the questions or attestations may result in a declination of my application and appointment with UnitedHealthcare.

Applicant's Signature

Date (MM/DD/YYYY)



**Please return all documents to your Recruiter
for submission to UnitedHealthcare.**

**UNITEDHEALTHCARE INSURANCE COMPANY
AGENT AGREEMENT**

This AGENT AGREEMENT (this “Agreement”) is made and entered into this ____ day of _____, 20____, by and between UnitedHealthcare Insurance Company (“United”), on behalf of itself and its Affiliates (collectively, the “Company”) and _____ (“Agent”).

- A. United and certain of its Affiliates offer Medicare Advantage Plans (“MA Plans”), stand-alone prescription drug plans (“PDP Plans”), Medicare supplement insurance plans (“Med Supp Plans”) and other health plans and products as may be designated by the Company (collectively, “Products”).
- B. FMO/NMA or General Agent has recommended Agent for appointment by the Company to market and promote the Products.

NOW, THEREFORE, in consideration of the mutual covenants in this Agreement, it is agreed as follows:

**ARTICLE ONE
DEFINITIONS**

As used herein, capitalized terms shall have the meanings set forth below:

- 1.1 **Affiliate** is any entity which directly or indirectly, through one or more intermediaries, owns or controls, is controlled or owned by or is under common ownership or control with the Company, and offers one or more of the Products. Affiliates offering the Products are specifically set forth in the Agent Compensation Schedule attached hereto and incorporated herein as **Exhibit A**.
- 1.2 **Agent** is an appropriately licensed, independent contractor, appointed by the Company, free to exercise his or its own judgment as to the time and manner of performing services pursuant to an agreement between the Agent and the Company.
- 1.3 **CMS** is the Centers for Medicare & Medicaid Services.
- 1.4 **CMS Contract** is the contract entered into by CMS and the Company pursuant to which the Company offers one or more MA Plans and/or one or more PDP Plans in a specified service area or region.
- 1.5 **FMO/NMA** is a Field Marketing Organization or National Marketing Alliance that has contracted with the Company to promote the Products and has directly or indirectly through a General Agent recommended Agent for appointment by the Company to market and promote the Products.
- 1.6 **General Agent** is an appropriately licensed, independent contractor, appointed by the Company, free to exercise his or its own judgment as to the time and manner of performing services pursuant to an agreement between the General Agent and the Company and authorized to recommend Agent for appointment by the Company to market and promote the Products. A General Agent can be categorized in any one of three levels, General Agent (GA), Super General Agent (SGA) or Master General Agent (MGA).
- 1.7 **MA Organization** is an entity that has entered into a contract with CMS to operate an MA Plan.
- 1.8 **MA Plan** is any Medicare Advantage Plan that may now or in the future be offered to individual Medicare beneficiaries by the Company including, but not limited to, Local HMO and PPO Plans (“Local MA Plans”), Special Needs Plans (“SNPs”), Regional Preferred Provider Plans (“Regional PPO Plans”) and Private Fee for Service Plans (“PFFS Plans”). The definition of an MA Plan includes an MA Plan which include prescription drug plan benefits (“MA-PD Plans”).

The following exhibits and attachments are incorporated by reference into this Agreement:

- ___ **Exhibit A** Agent Compensation Schedule
- ___ **Exhibit B** Medicare Regulatory Addendum
- ___ **Exhibit C** HIPAA Business Associate Addendum
- ___ **Exhibit D** Branded Products Addendum

Executed this ____ day of _____, 20__.

AGENT CONTRACTING AS

**UNITEDHEALTHCARE INSURANCE
COMPANY, on behalf of itself and its Affiliates**

(Check one)

- INDIVIDUAL**
- PARTNERSHIP**
- CORPORATION**

Print Name on License

By: _____
Authorized Signature

By: _____
Company Officer

Title: _____

Title: _____

Address

City State Zip Code

National Producer Number (required): _____



Electronic Funds Transfer

Medicare Solutions

To have your commission payments transferred electronically to your checking account or to change the checking account your funds are transferred to, complete the fund transfer authorization below. You will also need to attach a voided check from the checking account you wish to have your commission payments deposited in. Please do not send a deposit slip or cancelled check. Please return the completed authorization via email to sh_commissions_administration@uhc.com or fax it to 1-866-761-9162.

Fund Transfer Authorization

Please indicate: New Change

I (We) do hereby authorize UnitedHealthcare® to deposit all commission payments due me to the checking account indicated below and the Depository Financial Institution named below.

Account Number

Financial Institution Name

City

State

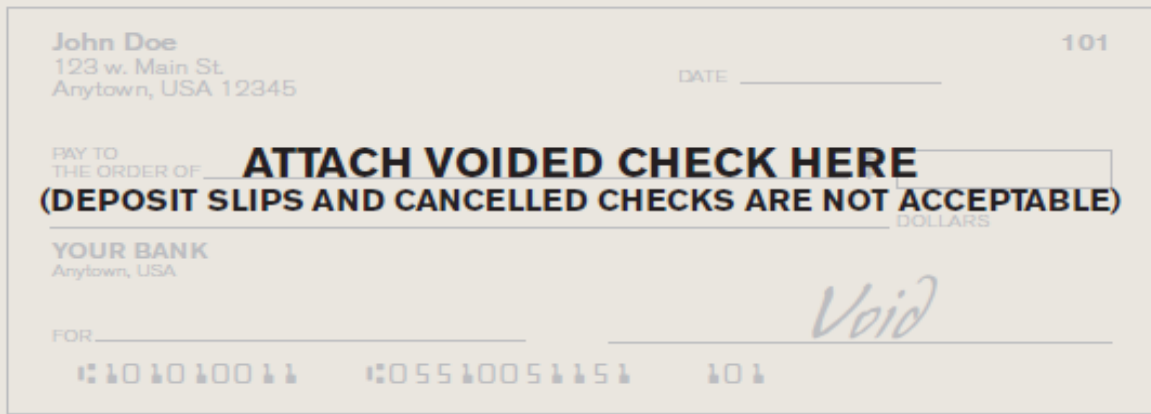
Please remember to notify us if the bank you use changes its name or merges with another bank or if you change banks and/or if you change bank accounts.

Agent Signature

Agent Printed Name

Agent Writing ID

Date



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: <input type="checkbox"/> Individual/ Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other ▶	
	<input type="checkbox"/> 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.

Social security number								
OR								
Employer identification number								

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

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,