National Insurance Benefit Coordinators, Inc.

Appointment Instructions for

Delta Dental

Please complete the following:

1. _____ **Request for Appointment:** Complete and sign.

2. _____ **Agent Fee Agreement:** Complete and sign.

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

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.

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.

National Insurance Benefit Coordinators, Inc.
112 Smart House Way
North Little Rock, AR 72114
(501) 372-4800 phone
(501) 372-2221 fax

REQUEST FOR APPOINTMENT WITH DELTA DENTAL OF ARKANSAS

Please answer all of the following questions and return to the Delta Dental of Arkansas Marketing Department for processing.

Name: _____
(We must have your full name, including your middle name)

SSN: _____ Date of Birth: _____

National Producer Number: _____ AR License Number: _____

FFM Number (Federally-facilitated Marketplace): _____

Business Address: _____

City, State, Zip: _____

Business Phone #: _____ Business Fax #: _____

Email Address: _____ Cell Phone Number: _____

Do you have an Arkansas Accident & Health producer license? _____ Yes _____ No

Date of initial licensure: _____

Is this your first appointment within the State of Arkansas? _____ Yes _____ No

Has your license ever been suspended, revoked, or have you ever been subject to disciplinary by any government regulator? _____ Yes _____ No If "yes", provide documentation.

Have you ever been convicted of a crime, had a judgment withheld or deferred, or are you currently charged with committing a crime**?** _____ Yes _____ No If "yes", provide documentation.

Have you or any business in which you are or were an owner, partner, officer, director, member or manager ever had any business relationship with an insurance company terminated for any alleged misconduct? _____ Yes _____ No If "yes", provide documentation.

Do you work alone? _____ Or with an Agency? _____

Must commissions be paid to an Agency? __X__ Yes _____ No
If yes, please complete Agency information.

AGENCY INFORMATION

Agency Name: National Insurance Benefit Coordinators, Inc.

Tax ID Number 20-4053278

FFM Number (Federally-facilitated Marketplace): _____

National Producer Number: 8701634 AR License Number: 100102765

Agency Mailing Address: 112 Smart House Way

City, State, Zip: North Little Rock, AR 72114

Agency Phone #: (501)372-4800 Fax #: (501)372-2221

Agency Contact Email Address: Karen@nibconline.com

List names & NIPR number of all agents in agency that will sell, solicit, or negotiate business for DDAR

_____

_____

Agent Fee Agreement

This Agent Fee Agreement (Agreement) is made effective on the date signed by the agent or an authorized represented of the agency. This Agreement is between Delta Dental Plan of Arkansas, Inc. (DDAR), an Arkansas-based, non-profit corporation, and the undersigned agent or agency ("Agent"). DDAR is designed to facilitate the provision of dental care by dentist to patient, and the undersigned Agent desires to sell the dental benefits being made available through DDAR.

In consideration of the mutual agreements set forth in this Agent Fee Agreement, the Schedule of Commissions, and any necessary Addendums, the parties agree as follows:

1) APPOINTMENT OF AGENT

a) **Authorization**. DDAR hereby authorizes Agent, while properly licensed as an insurance agent for health benefit coverages, to place such business on behalf of DDAR. Applications submitted will conform to DDAR's applicable underwriting regulations and other pertinent rules and regulations, as amended from time to time. No coverage will be effective until applications are approved by DDAR. Agent has a duty to verify all information on the applications and to notify DDAR of any changes in information submitted on the applications. DDAR may, at its sole discretion, suspend or withdraw all or any part of the Agent's authority as expressly described herein or as exists by virtue of the operation of this Agreement, at any time by providing written notice to the Agent. Said notice shall state the reason(s) for suspension or withdrawal, the term of the suspension or withdrawal, and the requirement(s) with which the Agent must comply for authority to be reinstated.

b) **Duties of Agent**. As an Agent of DDAR, you have the ongoing responsibility to maintain reasonable contact with the groups you represent on DDAR's behalf. It is expected that groups receive all information in a timely manner. Examples of such information are as follows:

1) Deliver new group package(s) and forward all necessary information to DDAR.
2) Educate group administrator(s) on DDAR's policies and underwriting guidelines.
3) Assist with enrollment of group(s).
4) Aid in resolution of group billing issue(s).
5) Deliver renewal packages to group(s) upon their receipt and educate group administrator(s) to the specifics of their renewal(s).

As the liaison between DDAR and group(s), it is also your duty to assist with group retention.

c) **License, Taxes, Indemnification, and Insurance**.

1) Agent certifies that he/she is duly licensed in the State of Arkansas and that such license is current and in good standing. In the event the Agent's license terminates, expires, or is suspended or revoked, Agent agrees to notify DDAR within ten (10) days after the date of such action. For the term of this Agreement, Agent shall obtain and keep in full force and effect any and all licenses required by the State of Arkansas in connection with the performance of duties under this Agreement and agrees to

conform to any and all laws of the state or local laws or regulations. Agent shall immediately forward to DDAR all complaints and inquiries from the Arkansas Insurance Department, public officials, or members of the general public which relate to DDAR.

2) Subject to the terms and conditions of this Agreement, including any supplements, amendments, or addenda hereto, the Agent is retained by DDAR only for the purposes and to the extent set forth in this Agreement. The Parties intend that this Agreement create an independent contractor relationship between them. Therefore, the Agent's relationship to DDAR shall, during the period of services hereunder, be that of an independent contractor. Agent shall not be considered under the provisions of this Agreement as having an employee status or being entitled to participate in any plans, arrangements, or distributions by DDAR pertaining to or in connection with any pension or welfare benefit plans or similar benefits for DDAR's regular employees. Agent shall indemnify and hold harmless DDAR from all liability from income, self-employment, unemployment, and any and all other taxes and levies upon the business of Agent.
3) Agent shall indemnify DDAR and hold DDAR harmless from any and all claims, liability, costs, expenses (including reasonable attorney's fees, court costs, and costs of appeal), damages, or losses occurring by reason of a breach by Agent of any of his/her obligations described in this Agreement or any action of or failure to act by the Agent either under this Agreement or in connection with the purchase of any benefit or insurance program by Agent's client(s).

2) COMPENSATION

a) Commissions shall be paid to the Agent with respect to contracts for group coverage (Groups), including a Group contract issued to an association, procured through the Agent so long as this Agreement and the Group contract are in effect, all required premiums have been received by DDAR, and the Agent:
   1) Is in compliance with all terms and conditions of this Agreement and DDAR's procedures.
   2) Is continuously and actively licensed and engaged as an Agent in the insurance business.
   3) Is recognized by the Group on the effective date of the Group contract (or renewal thereof) as the Agent of Record.
   No commission shall be paid on any Group contract for which premium has not been rated to include commissions or compensation. Attached and made part of this Agent Fee Agreement, you will find a Group Commission Schedule.

b) The initial Agent of Record designation must be made on the Group Application. Any change by the Group that results in a new Agent of Record will be recognized for the purpose of commission payment the 1st of the month following the receipt of any Agent of Record letter that meets the following criteria:
   1) Is on letterhead or other appropriate stationary.
   2) Is dated.
   3) Clearly designates by name the Agent to receive compensation and specifically rescinds by name all previous Agent designations.
   4) Is signed by an appropriate authorized representative of the Group.

The Agent shall cooperate with DDAR in effecting any change of Agent requested by any Group contracting with DDAR without any disruption of service to the Group. The Agent shall provide to the Group or to DDAR any copies of such records as may be necessary to effect such changes. Records, data, or information maintained by DDAR in connection with coverage under any contract shall at all times remain the property of DDAR.

c) Commissions shall not be payable on any premium waived, which waiver shall be at the sole discretion of DDAR, or any administration charge, late charge, or interest accumulation arising from due and payable premiums.

d) DDAR shall have the right to cancel, terminate, or alter the coverage under any contract executed with a Group according to the terms of said contract. Both during and after the termination of this Agreement, the Agent shall reimburse DDAR promptly (but in no event later than 30 days from demand) either by payment to DDAR or charge against the Agent's account for commissions paid to the Agent with respect to business written which for any reason is canceled, non-renewed, rescinded, or retroactively terminated provided the company will give the Agent timely notice of such cancellations, non-renewals, or rescissions of terminations.

3) GENERAL TERMS AND CONDITIONS

a) **Indebtedness of the Agent**. DDAR will have a first lien on all commissions payable hereunder for any debt due from the Agent to DDAR. DDAR may at any time deduct or set off from any monies payable under this Agreement, or from any other source any such debts due at any time from the Agent or to recover commission payments made in error. This lien and right of set off shall not be extinguished by the termination of this Agreement.

b) **Unauthorized Acts**. The Agent is without authority to do or perform and expressly agrees not to do or perform the following acts on behalf of DDAR:

1) Incur any indebtedness or liability.
2) Make, alter, or discharge contracts.
3) Quote rates other than as quoted by DDAR.
4) Waive payment or extend the time for payment of any premium.
5) Bind coverage.

In addition the Agent agrees not to:

6) Violate any insurance law or regulation.
7) Create communication material or forms without DDAR's specific written permission.
8) Withhold any monies or property of DDAR's.
9) Rebate or offer to rebate all or any part of a premium or contract coverage issued by the company.
10) Employ or make use of any advertisements, binders, endorsements, or any other materials not provided by DDAR that include the Delta name, corporate symbols, or registered marks of Delta without express prior written consent of DDAR.
11) Refuse to return, upon request, any printed matter, applications, sales literature, and other written material which DDAR may furnish Agent, and which shall remain the property of DDAR, subject at all times to its control and returnable upon demand.

12) Disclose or permit to be disclosed by Agent, its employee(s), representative(s), successor(s), underwriting, claims, actuarial, rating, financial materials/information or any other information which DDAR considers to be confidential and/or proprietary and which the Agent has obtained by reason of its association with DDAR. This includes DDAR's provider Maximum Plan Allowance (MPA) fees. The Agent further agrees to extend his/her best efforts to contain all such materials/information within his/her office premises. The confidentiality of such materials/information may be waived only by DDAR sending prior written notice to the Agent.

c) **Expenses**. The Agent shall be responsible for the payment of all expenses incurred pursuant to the exercise of any duties hereunder unless and until the reimbursement of such expenses has been first expressly authorized in writing by DDAR.

d) **Billing**. All individuals and groups shall be billed directly by DDAR and not through the Agent or other intermediary unless other billing arrangements are agreed to by both DDAR and Agent.

e) **Settlement for the Company**. The Agent has no right to receive monies for or on behalf of DDAR, except the initial premium on benefit coverages solicited by Agent, which initial premium shall be forwarded to DDAR promptly (but in no event later than ten days from the receipt by Agent). All monies received by the Agent for or on behalf of DDAR shall be received by the Agent as an agent of the proposed insured or Group in a fiduciary capacity, and immediately forwarded to the company.

f) **Records and Reports**. Agent shall forward to DDAR promptly (but in no event later than ten days from the receipt by Agent of completed application) all original applications and all original attachments thereto necessary to effect coverage. This provision shall survive the termination of this Agreement.

g) **Waiver**. Failure by DDAR to insist upon strict compliance with any of the terms, covenants, or conditions of this Agreement shall not be deemed to be a waiver of such term, covenant, or condition, nor shall any waiver or relinquishment of any right or power hereunder at any time constitute a course of conduct or be deemed a waiver or relinquishment of any further such rights or powers. No waiver shall be valid unless and until in writing and signed by a senior officer of DDAR.

h) **Amendment and Assignment**. DDAR may at any time amend the terms of this Agreement, including Commission Schedules. An amendment to the Commission Schedules applicable to the renewal of Group contracts shall apply to the renewals occurring subsequent to the effective date of such amendment. Each new Commission Schedule shall become part of this Agreement and shall apply to all commissions paid after the effective date of said amendment. DDAR will provide the Agent with written notice 60 days in advance of the effective date(s) of any such amendment(s). No modification or amendment to the Agreement or assignment, transfer or disposal of any interest that the Agent may have under this Agreement shall be binding upon DDAR at any time unless and until approved in writing by a senior officer of DDAR. This Agreement shall inure to any successor(s) in interest of DDAR.

i) **Termination**. This Agreement may be terminated at any time by either party by a 30 day notice in writing, provided, however, this Agreement shall terminate immediately upon written notice by DDAR to the Agent if DDAR has reason to believe the Agent has committed fraud or misrepresentations or breached any provision of this Agreement. In addition, the authority of the Agent shall be immediately terminated without notice by the

death or dissolution of the Agent, the violation of paragraph 3(b) hereof, or if the license granted to the Agent is suspended, canceled, or revoked at any time. Upon the termination of this Agreement, the Agent shall immediately pay in cash all sums due hereunder and shall immediately deliver to DDAR all materials furnished to the Agent by DDAR and any rate books, letters, forms, records, supplies, or any other materials related to the business of DDAR.

j) **Construction and Notices**. This Agreement is made and executed in the State of Arkansas and shall be enforced in accordance with the laws of the State of Arkansas. If any part of this Agreement is held void for any reason determined to be legally unenforceable, then such part shall be considered deleted to the extent necessary to avoid such prohibition and render the balance of the Agreement valid. All notices provided for under this Agreement shall, at the option of the sender, be either personally served upon the party to whom such notice is directed, or shall be mailed using certified mail with return receipt requested to the party to whom it was directed, and such notice shall constitute full and adequate notice on the date notice is received be the party to whom it is directed.

k) **Entire Agreement**. This Agreement supersedes any and all prior agreements, contracts, and understandings between the parties and shall govern all existing business between Agent and DDAR.

l) **Headings**. The headings of this Agreement are inserted for reference purposes only and are not restrictive as to content.

4) EXHIBIT.

The parties understand and agree that the attached Exhibit, HIPAA Privacy Business Associate Agreement, is incorporated by reference and made a part of this Agent Fee Agreement, and that by signing this Agent Fee Agreement each party is also bound by the terms of the HIPAA Privacy Business Associate Agreement.

Ed Choate

By:_____ By:_____

Delta Dental Plan of Arkansas, Inc. Agent

Print Name: Ed Choate Print Name: _____

Date:_____ Date:_____

HIPAA PRIVACY BUSINESS ASSOCIATE AGREEMENT

This Agreement is entered into between Delta Dental Plan of Arkansas, Inc. (including its subsidiary Omega Administrators, Inc.) ("Covered Entity") and <Agency Name> (including the agent or agency's Workforce, as defined below) that is a party to the Agent Fee Agreement to which this Agreement is incorporated ("Business Associate") (hereinafter collectively referred to as the "Parties"). This Agreement is in effect as of September 1, 2014. This Agreement is incorporated into any and all contracts between the Parties (the "Contract(s)"). The Parties intend to use this Agreement to satisfy the Business Associate contract requirements in the regulations at 45 CFR 164.502(e) and 164.504(e), issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as modified under the final regulations issued January 25, 2013 (the "Final Rule"). This Agreement is also intended to incorporate the requirements of the Health Information Technology for Economic and Clinical Health Act, part of the American Recovery and Reinvestment Act of 2009, and its regulations as issued and amended by the Secretary ("HITECH"), as they relate to the obligations of Business Associate.

1.0 Definitions

Terms used but not otherwise defined in this Agreement shall have the same meaning as those terms in 45 CFR 160.103, 160.402, and 164.501. Notwithstanding the above, "Secretary" shall mean the Secretary of the U.S. Department of Health and Human Services or his/her designee; "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E; "Electronic Transactions Rule" shall mean the final regulations issued by the Secretary concerning standard transactions and code acts under 45 CFR part 160 and part 162; "Security Rule" shall mean the Security Standards and Implementation Specifications at 45 CFR part 160 and part 164, subpart C; "Breach" shall have the meaning as set forth in 45 CFR §164.402; and "Security Incident" shall have the same meaning as set forth in 45 CFR §164.304. The definition of "Workforce" means employees, volunteers, trainees, independent contractors, and any other individual or entity that is or is held out to be associated with the Business Associate (for example, a licensed agent), whether or not they are paid by the Business Associate.

2.0 Obligations and Activities of Business Associate

(a) Business Associate agrees to not use or disclose Protected Health Information other than as permitted or required by Section 3.0 of this Agreement, or as Required by Law. This Agreement does not authorize Business Associate to use or disclose Protected Health Information in any manner that will violate the Privacy Rule if done by Covered Entity, except as permitted for Business Associate's proper management or administration as described herein.

(b) Business Associate agrees to use appropriate administrative, physical and technical safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement. Business Associate will implement administrative, physical, and technical safeguards (including written policies and procedures) that reasonably and

appropriately protect the confidentiality, integrity, and availability of Electronic Protected Health Information that Business Associate creates, receives, maintains, or transmits on behalf of Covered Entity as required by the Security Rule.

(c) Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate (or its agents or Subcontractors) in violation of the requirements of this Agreement.

(d) Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement of which it becomes aware, including any Breach of Unsecured Protected Health Information as required under 45 CFR 164.410 and any Security Incident of which it becomes aware. The Breach will be treated as being discovered in accordance with 45 CFR 164.410, and Business Associate will report the Breach to Covered Entity as soon as possible but in no event later than ten (10) calendar days following the discovery of the Breach unless a delay is requested by a law-enforcement official in accordance with 45 CFR 164.412. Business Associate shall include in its report to the Covered Entity, the following information regarding the Breach, to the extent possible:

(i) The identity of each individual whose Unsecured Protected Health Information has been or is reasonably believed to have been breached;

(ii) Identify the nature of the Breach, which includes a brief description of what happened, the date of the Breach, and the date of the discovery of the Breach;

(iii) A description of the types of Unsecured Protected Health Information involved in the Breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information involved);

(iv) A description of what the Business Associate is doing to investigate the Breach, mitigate harm to individuals, and to protect against any further Breaches;

(v) Identify what steps, if any, the individuals who were subject to a Breach should take to protect themselves, including any contact procedures the Business Associate will make available for individuals to ask questions or learn additional information; and

(vi) Any additional information, including written reports and risk assessment under 45 CFR 164.402, the Covered Entity may reasonably request in its discretion.

Such information shall be provided by Business Associate to Covered Entity within the time specified above, however, if such information is not available at such time, Business Associate shall not delay the initial notification of the Breach to Covered Entity and shall take all reasonable steps necessary to promptly collect and provide such additional information to Covered Entity as the information becomes available in accordance with 45 CFR 164.410.

To the extent that a Breach occurs as a result of the Business Associate's, or one of its Subcontractor's, failure to comply with one or more of its obligations under this Agreement, Covered Entity may, upon providing written notification to Business Associate, require Business Associate to provide notification of a Breach applicable to all third parties in satisfaction of Covered Entity's obligations under 45 CFR §164. Upon receiving notification from Covered Entity, Business Associate agrees to take all necessary steps to ensure that the third party Breach notifications are provided, to the satisfaction of Covered Entity, in a time and manner sufficient to comply with Covered Entity's obligations under 45 CFR 164, and agrees to pay for all costs associated with such Breach and such required notifications.

(e) In accordance with 45 CFR §164.502(e)(1)(ii), Business Associate agrees to enter into a written contract with any agent or Subcontractor that creates, receives, maintains, or transmits Protected Health Information and/or Electronic Protected Health Information on behalf of Business Associate, and agrees that such contract shall obligate Business Associate's agent or Subcontractor, as applicable, to abide by the same restrictions and conditions with respect to use and disclosure of the Protected Health Information as Business Associate is required to abide by and implement in accordance with this Agreement. In addition, Business Associate shall ensure that any such agent or Subcontractor agrees to implement reasonable and appropriate safeguards to protect Covered Entity's Protected Health Information and/or Electronic Protected Information in accordance with 45 CFR §164.308(b)(2). Furthermore, Business Associate shall be responsible for any failure of Business Associate's Workforce to abide by the same restrictions and conditions with respect to use and disclosure of the Protected Health Information as Business Associate is required to abide by in accordance with this Agreement.

(f) Business Associate agrees to provide access within 10 days following the request of Covered Entity to the Covered Entity (or, upon direction of Covered Entity, directly to an individual) for inspection and copying Protected Health Information about the individual in a Designated Record Set that is in the Business Associate's custody or control in order for Covered Entity to meet the requirements under 45 CFR 164.524. Effective as of the date set forth in the Final Rule, if Covered Entity requests an electronic copy of Protected Health Information, Business Associate agrees to provide an electronic copy of the Protected Health Information if such Protected Health Information is maintained electronically in a Designated Record Set in the Business Associate's custody and control and is readily producible in such format or, if not, in a readable electronic form and format as agreed to by Covered Entity and Business Associate in order for Covered Entity to meet its electronic access obligations under 45 CFR §164.524. Business Associate shall notify Covered Entity in writing within ten (10) calendar days of Business Associate's receipt of any such request other than from Covered Entity and shall, at Covered Entity's request, provide Covered Entity with a copy of any Protected Health Information so accessed.

(g) Business Associate agrees to make any Amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entity or an individual directs or agrees to pursuant to 45 CFR 164.526 at the request of Covered Entity or an individual, and in a prompt and reasonable manner consistent with the HIPAA regulations. Business Associate shall notify Covered Entity in writing within ten (10) calendar days of Business Associate's receipt of

any such request other than from Covered Entity and shall, at Covered Entity's request, provide Covered Entity with a copy of any Protected Health Information so amended.

(h) Business Associate agrees to make its internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, or at the request of the Covered Entity, to the Secretary in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule. Business Associate shall immediately notify Covered Entity, in writing, upon Business Associate's receipt of any such request and shall, at Covered Entity's request, provide Covered Entity with a copy of any such request and any materials so accessed.

(i) Business Associate agrees to document disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528. Business Associate shall notify Covered Entity in writing within ten (10) calendar days of Business Associate's receipt of any such request for an accounting, other than from Covered Entity, and shall at Covered Entity's request, provide Covered Entity with a copy of the accounting so provided. Business Associate shall maintain documentation of disclosures of Protected Health Information for a period of at least six (6) years following the date of such disclosure.

(j) Business Associate agrees to provide to Covered Entity or an individual an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528, in a prompt and reasonable manner consistent with the HIPAA regulations.

(k) Business Associate agrees to satisfy all applicable provisions of HIPAA standards for the Electronic Transactions Rule and further agrees to ensure that any agent, including a Subcontractor, that conducts standard transactions on its behalf will comply with the Electronic Transactions rule to the extent required by law.

(l) Business Associate agrees to make reasonable efforts to limit any use, disclosure or request of Protected Health Information to the Minimum Necessary to accomplish the intended purpose of the use, disclosure or request in accordance with the Privacy Rule. Business Associate agrees that the Minimum Necessary determination shall be made in accordance with Covered Entity's Minimum Necessary policies and procedures together with applicable guidance under HITECH and the HIPAA rules.

(m) Business Associate agrees, effective as of the date of this Agreement, to not directly or indirectly receive remuneration in exchange for any Protected Health Information of an individual unless the Covered Entity obtained from the individual, in accordance with 45 CFR 164.508, a valid authorization that includes a specification of whether the Protected Health Information can be further exchanged for remuneration by the entity receiving Protected Health Information of that individual except as set forth under HITECH.

(n) Business Associate agrees to comply, and will require any agent (including Subcontractors) it employs to comply, with the applicable provisions of the Standards for Electronic Transactions Rule, and with the National Provider Identifier requirements (to the extent applicable) and any other rules or requirements established by HHS with respect to such transaction.

(o) Business Associate agrees to report on a monthly basis to Covered Entity any Security Incidents resulting from any attempted or successful (i) unauthorized access, use, disclosure, modification, or destruction of Electronic Protected Health Information, or (ii) interference with Business Associate's information system, of which Business Associate becomes aware. Notwithstanding the foregoing, if such Security Incident resulted in a use or disclosure not permitted by this Agreement or a breach of Unsecured Protected Health Information, Business Associate will report such incident as set forth in paragraph (d) above.

(p) Business Associate shall not use or disclose Genetic Information for underwriting purposes in violation of HIPAA.

(q) To the extent Business Associate is responsible for carrying out one or more obligations of Covered Entity under Subpart E of 45 CFR Part 164, Business Associate agrees to comply with the requirements of Subpart E that apply to Covered Entity in the performance of such obligation(s).

(r) Business Associate agrees that it is directly subject to the requirements of the Privacy Rule and the Security Rule in accordance with HITECH and the Final Rule, subject to civil and criminal penalties for failure to comply with such requirements.

(s) Personally Identifiable Information. Business Associate shall implement commercially reasonable measures to safeguard the privacy and security, in accordance with applicable law, of Personally Identifiable Information. For purposes of this Agreement, "Personally Identifiable Information" shall have the meaning ascribed to such term or like terms as set forth in applicable privacy, security and data breach notification laws, limited to information that Business Associate creates, receives, maintains or transmits on behalf of Covered Entity. Business Associate shall notify Covered Entity of any breach of any such Personally Identifiable Information for which notification is required by applicable law, including state data breach notification laws. Such notification shall be made promptly and in a manner which permits the timely provision of required notifications to individuals or governmental authorities under applicable law. Business Associate agrees to establish policies and procedures for mitigating, to the greatest extent practicable, any harmful effect from any breach of Personally Identifiable Information. The provisions of this Section shall not be construed to limit any other provision of this Agreement.

3.0 Permitted or Required Uses and Disclosures by Business Associate

(a) General Use and Disclosure. Business Associate provides services to, or on behalf of, Covered Entity as further described in the Contract(s) entered into by and between Covered Entity and Business Associate. Except as otherwise limited in this Agreement, Business

Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract and in this Agreement, provided that such use or disclosure of Protected Health Information would not violate the Privacy Rule, including the Minimum Necessary (as interpreted in accordance with HITECH and guidance from the Secretary) requirement, if done by Covered Entity.

(b) Additional use and disclosure. Except for the specific uses and disclosures set forth below, Business Associate may not use or disclose Protected Health Information in a manner that would violate Subpart E of 45 CFR Part 164 if done by the Covered Entity.

(i) Except as otherwise limited in the Contract or this Agreement, Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

(ii) Except as otherwise limited in this Agreement, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, provided that such disclosures are Required by Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and be used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

(iii) Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information to provide Data Aggregation services related to health care operations of Covered Entity as permitted by 45 CFR 164.504(e)(2)(i)(B).

(iv) Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 45 CFR 164.502(j)(1).

(v) Business Associate may use Protected Health Information to de-identify the information in accordance with 45 CFR §164.514(a)-(c) only upon receiving express written authorization from Covered Entity.

4.0 Obligations of Covered Entity to Inform Business Associate of Covered Entity's Privacy Practices, and any Authorization or Restrictions

(a) Covered Entity shall notify Business Associate of any limitation(s) in the notice of privacy practices that Covered Entity produces under 45 CFR 164.520 to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information.

(b) Covered Entity shall notify Business Associate of any changes in, or revocation of, the permission by an individual to use or disclose his or her Protected Health Information, to the

extent that such changes may affect Business Associate's uses or disclosures of Protected Health Information.

(c) Covered Entity shall notify Business Associate of any restriction on the use or disclosure of Protected Health Information that Covered Entity has agreed to or is required to abide by under 45 CFR 164.522 to the extent that such restriction affects Business Associate's uses or disclosures of Protected Health Information. Business Associate shall comply with and honor any restriction requests to restrict disclosure of Protected Health Information pursuant to 45 CFR 164.522(a) or to provide confidential communications of Protected Health Information pursuant to 45 CFR §164.522(b). Covered Entity will notify Business Associate in writing of the termination of any request for restrictions or confidential communications.

5.0 Permissible Requests by Covered Entity

Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

6.0 Term and Termination

(a) *Term*. The Term of this Agreement shall be effective as of the date this Agreement is entered into**,** and shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section.

(b) *Termination for Cause.* Without limiting the termination rights of the parties pursuant to the Contract, and upon Covered Entity's knowledge of a material breach by Business Associate of a provision under this Agreement, Covered Entity shall provide an opportunity for Business Associate to cure the breach or end the violation and terminate the Contract if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity, or immediately terminate the Contract if Business Associate has breached a material term of this Agreement and cure is not possible. If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

(c) *Effect of Termination.* The parties mutually agree that it is essential for Protected Health Information to be maintained after the expiration of the Agreement for regulatory and other business reasons. Upon termination of this Agreement, for any reason, Business Associate shall return to Covered Entity or, if agreed by Covered Entity, destroy all Protected Health Information received from Covered Entity or created, maintained or received by Business Associate on behalf of Covered Entity that Business Associate still maintains in any form. The parties further agree that if it would be infeasible for Covered Entity to maintain such records because Covered Entity lacks the necessary system and expertise, at the election of Covered Entity, Covered Entity shall appoint Business Associate as its custodian for the safe keeping of any record-containing Protected Health Information that Business Associate may

determine it is appropriate to retain. Notwithstanding the expiration or termination of the Contract, Business Associate shall extend the protections of this Agreement to such Protected Health Information, and limit further use or disclosure of the Protected Health Information to those purposes that make the return or destruction of the Protected Health Information infeasible for as long as Business Associate maintains such Protected Health Information. This provision shall apply to Protected Health Information that is in the possession of agents (including Subcontractors) of Business Associate.

7.0 Miscellaneous

(a) *Entire Agreement*. This Agreement constitutes the entire agreement of the Parties with respect to the Parties' obligations under the business associate provisions of 45 C.F.R. parts 160 and 164. This Agreement supersedes all prior or contemporaneous written or oral memoranda, arrangements, contracts or understandings between the Parties hereto relating to the Parties' compliance with Parties' health information confidentiality and security obligations under 45 C.F.R. parts 160 thorough 164.

(b) *Regulatory References.* A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended, and for which compliance is required.

(c) *Amendment.* Upon the enactment of any law or regulation affecting the use or disclosure of Protected Health Information, or the publication of any decision of a court of the United States or any state relating to any such law or the publication of any interpretive policy or opinion of any governmental agency charged with the enforcement of any such law or regulation, either party may, by written notice to the other party, amend the Contract and this Agreement in such manner as such Party determines necessary to comply with such law or regulation. If the other Party disagrees with such Amendment, it shall so notify the first Party in writing within thirty (30) days of the notice. If the Parties are unable to agree on an Amendment within thirty (30) days thereafter, then either of the Parties may terminate the Contract on thirty (30) days written notice to the other Party.

(d) *Survival.* The respective rights and obligations of Business Associate under Section 6.0 of this Agreement shall survive the termination of this Agreement.

(e) *Interpretation.* Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with the Privacy Rule and Security Rule.

(f) *Severability*. In the event any portion of this Agreement is held invalid or unenforceable, such determination shall not affect the remaining terms and provisions hereof that may be given effect without such invalid or unenforceable provisions, and to this end the provisions of this Agreement are declared to be severable.

(g) *No third party beneficiary*. Nothing expressed or implied in this Agreement or in the Contract is intended to confer, nor shall anything herein confer, upon any person other than the Parties and the respective successors or assignees of the Parties, any rights, remedies, obligations, or liabilities whatsoever.

(h) *Governing Law*. This Agreement shall be governed by and construed in accordance with the laws of the state of Arkansas to the extent not preempted by the Privacy Rules or other applicable federal law.

(i) *Affiliates*. This Agreement shall be binding upon the Parties and their current and future Affiliates, successors and permitted assigns. "Affiliate" shall mean any entity owned or controlled by, under common ownership or control with, or which owns or controls, either party to this Agreement or any of its subsidiaries.

(j) *Indemnification*. Business Associate will indemnify Covered Entity and hold Covered Entity harmless against any losses, liabilities, penalties, fines, costs, damages, and expenses, including reasonable attorneys' fees, Covered Entity incurs as a result of Business Associate's breach of the terms of this Agreement or any other failure of the Business Associate (or its agents or Subcontractors) to comply with the requirements of the Privacy Regulations for which Covered Entity may be held liable. Covered Entity will indemnify Business Associate and hold Business Associate harmless against any losses, liabilities, penalties, fines, costs, damages, and expenses, including reasonable attorneys' fees, Business Associate incurs as a result of Covered Entity's breach of the terms of this Agreement or any other failure of the Covered Entity (or its agents or subcontractors) to comply with the requirements of the Privacy Regulations for which Business Associate may be held liable. This provision will survive termination of this Agreement.

(k) *Waiver*. No forbearance or neglect on the part of Covered Entity nor Business Associate to enforce or insist upon any of the applicable provisions of this Agreement shall be construed as a waiver of Covered Entity's or Business Associate's rights hereunder unless it is in writing and signed by a duly authorized officer of Covered Entity and Business Associate. A waiver with respect to one event shall not be construed as continuing, or as a bar to or as a waiver of any right or remedy as to subsequent events.

(l) *Notice*. Any notice to be given hereunder to a Party shall be made via registered or certified mail, postage prepaid, return receipt requested, or express courier. Notice shall be given to the individual at the addresses in the signature block below. Notice shall be effective upon receipt.

(m) *Assignment*. This Agreement is not assignable.

Dental Commission Guidelines for Insured Accounts*

Effective January 1, 2011

Potential Group Size:	Contributory/Non-Contributory Commission Schedule	Voluntary Commission Schedule
Individual Subscriber	10%	10%
2 to 9 Lives	10%	10%
10 to 59 Lives	10%	10%
60 to 99 Lives	6%	10%
100 to 149 Lives	5%	10%
150 to 499 Lives	3%	10%
500 + Lives	3%	3%

Commission for all groups may be negotiated under certain circumstances.

**Self-Funded group commissions will be handled on a case-by-case basis for all group sizes.*

Vision Commission Guidelines for Insured Accounts

Rates include 10% commission.

Please remember that there is an 80/20 split of the above commissions with NIBC.

_____ _____

Signature Date

IMPORTANT FAIR CREDIT REPORTING ACT DISCLOSURE & AUTHORIZATION

The purpose of this form is to notify you that a consumer report will be run on you in the course of Delta Dental of Arkansas' consideration of your request to be appointed as an agent.

As an applicant to become an agent for Delta Dental of Arkansas (Delta Dental), you are considered to be a consumer with rights under the Fair Credit Reporting Act (FCRA). Under this law, Delta Dental may procure a *consumer report* from a *consumer reporting agency* on you when (1) considering your application for appointment, (2) making a decision with respect to your application for appointment, (3) deciding whether to continue your appointment, and/or (4) making other decisions affecting you with respect to your appointment.

A "consumer reporting agency" is a person or business that, for monetary fees, dues or on a cooperative non-profit basis, regularly assembles or evaluates consumer credit information or other information on consumers for the purpose of furnishing consumer reports to others, such as Delta Dental.

A "consumer report" means any written, oral, or other communication bearing on your credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living which is used in whole or in part for the purpose of serving as a factor in establishing your eligibility to be appointed as an agent by Delta Dental and/or maintaining that appointment.

Pursuant to requirements of the Arkansas Insurance Department with regard to the processing of agent appointments and terminations, Delta Dental is required to access the National Insurance Producer Registry (NIPR) which is an affiliate of the National Association of Insurance Commissioners (NAIC). NIPR considers itself to be a "consumer reporting agency" and the information contained its database to be a "consumer report" under the FCRA. For these reasons, NIPR requires that insurance companies accessing its database disclose to agents that the insurance company will access agent's information in NIPR's database and that access is subject to the requirements of the FCRA.

Should any of the information from a consumer report be utilized by Delta Dental in whole or in part in making an adverse decision regarding your appointment, before making the adverse decision, Delta Dental will provide you with a copy of the consumer report, the name, address, and telephone number of the consumer reporting agency, and a summary of your rights under the FCRA. A copy of those rights is also included with this notice.

AUTHORIZATION

By signing below, I, _____ (Print Name) hereby confirm that I have read and understand the foregoing disclosure and I further voluntarily authorize Delta Dental Plan of Arkansas, Inc. to obtain a consumer report about me from a consumer reporting agency and to consider this information when making a decision with respect to my request for and/or my ongoing appointment as an agent with Delta Dental of Arkansas, Inc. I understand that I have rights under the Federal Fair Credit Reporting Act, including those rights as described above. This authorization, in original or copy form, shall be valid for this and any future reports or updates that may be requested.

_____ _____

Signature Date

Para informacion en espanol, visite www.consumerfinance.gov/learnmore o escribe a la Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.

A Summary of Your Rights Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. **For more information, including information about additional rights, go to www.consumerfinance.gov/learnmore or write to: Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.**

- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.
- **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your "file disclosure"). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
  - a person has taken adverse action against you because of information in your credit report;
  - you are the victim of identity theft and place a fraud alert in your file;
  - your file contains inaccurate information as a result of fraud;
  - you are on public assistance;
  - you are unemployed but expect to apply for employment within 60 days.

In addition, all consumers are entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.consumerfinance.gov/learnmore for additional information.

- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.
- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.consumerfinance.gov/learnmore for an explanation of dispute procedures.
- **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.
- **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.
- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need -- usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.
- **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.consumerfinance.gov/learnmore.
- **You may limit "prescreened" offers of credit and insurance you get based on information in your credit report.** Unsolicited "prescreened" offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-567-8688.
- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a

- consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
- **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.consumerfinance.gov/learnmore.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. For information about your federal rights, contact:

TYPE OF BUSINESS:	**CONTACT:**
1.a. Banks, savings associations, and credit unions with total assets of over $10 billion and their affiliates. b. Such affiliates that are not banks, savings associations, or credit unions also should list, in addition to the CFPB:	a. Consumer Financial Protection Bureau 1700 G Street, N.W. Washington, DC 20552 b. Federal Trade Commission: Consumer Response Center – FCRA Washington, DC 20580 (877) 382-4357
2. To the extent not included in item 1 above: a. National banks, federal savings associations, and federal branches and federal agencies of foreign banks b. State member banks, branches and agencies of foreign banks (other than federal branches, federal agencies, and Insured State Branches of Foreign Banks), commercial lending companies owned or controlled by foreign banks, and organizations operating under section 25 or 25A of the Federal Reserve Act c. Nonmember Insured Banks, Insured State Branches of Foreign Banks, and insured state savings associations d. Federal Credit Unions	a. Office of the Comptroller of the Currency Customer Assistance Group 1301 McKinney Street, Suite 3450 Houston, TX 77010-9050 b. Federal Reserve Consumer Help Center P.O. Box 1200 Minneapolis, MN 55480 c. FDIC Consumer Response Center 1100 Walnut Street, Box # 11 Kansas City, MO 64106 d. National Credit Union Administration Office of Consumer Protection (OCP) Division of Consumer Compliance and Outreach (DCCO) 1775 Duke Street Alexandria, VA 22314
3. Air carriers	Asst. General Counsel for Aviation Enforcement & Proceedings Aviation Consumer Protection Division Department of Transportation 1200 New Jersey Avenue, S.E. Washington, DC 20590
4. Creditors Subject to the Surface Transportation Board	Office of Proceedings, Surface Transportation Board Department of Transportation 395 E Street, S.W. Washington, DC 20423
5. Creditors Subject to the Packers and Stockyards Act, 1921	Nearest Packers and Stockyards Administration area supervisor
6. Small Business Investment Companies	Associate Deputy Administrator for Capital Access United States Small Business Administration 409 Third Street, SW, 8th Floor Washington, DC 20416
7. Brokers and Dealers	Securities and Exchange Commission 100 F Street, N.E. Washington, DC 20549
8. Federal Land Banks, Federal Land Bank Associations, Federal Intermediate Credit Banks, and Production Credit Associations	Farm Credit Administration 1501 Farm Credit Drive McLean, VA 22102-5090
9. Retailers, Finance Companies, and All Other Creditors Not Listed Above	FTC Regional Office for region in which the creditor operates or Federal Trade Commission: Consumer Response Center – FCRA Washington, DC 20580 (877) 382-4357

Form **W-9**
(Rev. December 2014)
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.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

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

Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

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

Requester's name and address (optional)

6 City, state, and ZIP code

7 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 generally 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 instructions for line 1 and 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. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

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 3.

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

General Instructions

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

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

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, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

National Benefit Coordinators

Direct Deposit Enrollment and Authorization Form
(Authorization Agreement for Electronic Transfer of Funds via ACH Credits)

Instructions:

1. Complete this entire authorization agreement. Please print using black or blue ink.
2. Present this completed form to the company's financial office. If your checking account will be credited, please attach to this form a voided check for the checking account. If your savings account will be credited, please attach to this form a voided deposit slip for the savings account.
3. This agreement may be revised or terminated at any time by written notification or email to the company's financial office.

YOUR INFORMATION

Check appropriate box:	Last Name:	First Name and Middle Initial:
☐ New Enrollment/Authorization ☐ Change in Bank Account ☐ Cancel Participation	Street Address:	
	City:	State and Zip Code:
	Daytime Phone: ( )	Evening Phone: ( )

CHECKING OR SAVINGS ACCOUNT ACH CREDIT AUTHORIZATION

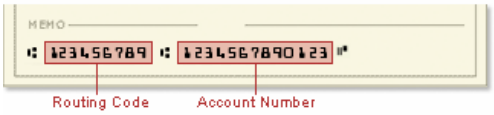
Payroll deposits should be credited to my:

☐ Checking Account (Please attach a voided check.)

☐ Savings Account (Please attach a deposit slip.)

Routing Number (9 Digits): _____

Account Number: _____



Company Use Only:

ACH Transaction Set Up on ____/____/____ by _____

Individual ID Assigned: _____

I hereby authorize *National Benefit Coordinators* to automatically deposit payroll into my account by initiating ACH credit transactions per the information stated on this form. I also authorize *National Benefit Coordinators* to initiate debit entries to my account, should such entries be necessary to correct incorrect entries. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of NACHA requirements. This authorization will remain in effect until *National Benefit Coordinators* has received written notification from me of its termination in such time and in such manner as to afford *National Benefit Coordinators* a reasonable opportunity to act on it.

Account Holder Signature: _____

Date: _____/_____/_____

Form **W-9**
(Rev. December 2014)
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.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

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

Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

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

Requester's name and address (optional)

6 City, state, and ZIP code

7 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 generally 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 instructions for line 1 and 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. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

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 3.

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

General Instructions

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

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

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- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

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, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

National Benefit Coordinators

Direct Deposit Enrollment and Authorization Form
(Authorization Agreement for Electronic Transfer of Funds via ACH Credits)

Instructions:

1. Complete this entire authorization agreement. Please print using black or blue ink.
2. Present this completed form to the company's financial office. If your checking account will be credited, please attach to this form a voided check for the checking account. If your savings account will be credited, please attach to this form a voided deposit slip for the savings account.
3. This agreement may be revised or terminated at any time by written notification or email to the company's financial office.

YOUR INFORMATION

Check appropriate box:	Last Name:	First Name and Middle Initial:
☐ New Enrollment/Authorization ☐ Change in Bank Account ☐ Cancel Participation	Street Address:	
	City:	State and Zip Code:
	Daytime Phone: ( )	Evening Phone: ( )

CHECKING OR SAVINGS ACCOUNT ACH CREDIT AUTHORIZATION

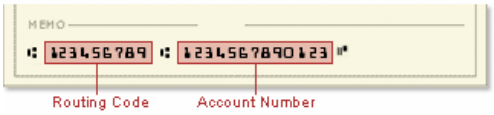
Payroll deposits should be credited to my:

☐ Checking Account (Please attach a voided check.)

☐ Savings Account (Please attach a deposit slip.)

Routing Number (9 Digits): _____

Account Number: _____



Company Use Only:

ACH Transaction Set Up on ____/____/____ by _____

Individual ID Assigned: _____

I hereby authorize *National Benefit Coordinators* to automatically deposit payroll into my account by initiating ACH credit transactions per the information stated on this form. I also authorize *National Benefit Coordinators* to initiate debit entries to my account, should such entries be necessary to correct incorrect entries. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of NACHA requirements. This authorization will remain in effect until *National Benefit Coordinators* has received written notification from me of its termination in such time and in such manner as to afford *National Benefit Coordinators* a reasonable opportunity to act on it.

Account Holder Signature: _____

Date: _____/_____/_____