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 kristin@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

Please answer all of the following questions and return to DDPAR for processing.

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

Home Address: _____

City, State, Zip: _____

Phone Number: _____ SSN: _____

Business Address: _____

City, State, Zip: _____

Business Phone #: _____ Business Fax #: _____

Do you have an Arkansas Disability license? _____ Yes _____ No

How long have you been licensed? _____

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

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

Has your license ever been suspended? _____ Yes _____ No

Must commissions be paid to an Agency? X Yes _____ No
If yes, please give Tax ID # 20-4053278

Agency Name: National Insurance Benefit Coordinators, Inc.

Agency Mailing Address: 112 Smart House Way

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

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

Email Address: kristin@nibconline.com

List names & SSN of all agents in agency licensed for Disability

_____

_____

_____

Two References (Business or Personal)

Name: _____ Name: _____

Address: _____ Address: _____

City: _____ City: _____

Phone #: _____ Phone #: _____

Signature _____ Date _____

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 supercedes 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, Agent 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 Agent Business Associate Agreement.

By:_____ By:_____

Delta Dental of Arkansas Agent

Print Name: Jay Reavis Print Name: _____

Date:_____ Date:_____

Form **W-9**
(Rev. January 2003)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

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

Name

Business name, if different from above

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

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

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

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

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

Social security number
| | | | – | | – | | | | |

or

Employer identification number
| | | – | | | | | | | |

Part II Certification

Under penalties of perjury, I certify that:

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

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

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

Purpose of Form

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

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

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee.

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.*

Foreign person. If you are a foreign person, use the appropriate Form W-8 (see **Pub. 515,** Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

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

National Insurance 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

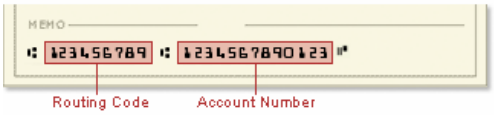
Payroll deposits should be credited to my:

☐ 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 Insurance 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 Insurance 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 Insurance Benefit Coordinators* has received written notification from me of its termination in such time and in such manner as to afford *National Insurance Benefit Coordinators* a reasonable opportunity to act on it.

Account Holder Signature: _____

Date: _____/_____/_____