

**Assurity® Life Insurance Company**

1526 K Street • PO Box 82533

Lincoln, NE 68501-2533

Toll Free 800-276-7619

**Long Term Care Insurance License Appointment Checklist**

The procedure for licensing agents differs in each state. All states, however, are uniform in requiring that an agent be properly licensed **before** soliciting insurance sales. Assurity supports this position and requests your complete compliance with the licensing laws of your state(s). Please review the Appointment Guidelines for Business Received (reverse side) for more information.

**You must return all of the following items completed in full to Contracting at Assurity. Information should be typed or printed legibly. Missing items will delay the contracting and appointment process.**

**Appointment Application**

When appointing an agency, you must include **both** the tax identification number and social security number on the Appointment Application.

\*\* The e-mail address and other information provided is confidential and will be used for Assurity business purposes only. E-mail addresses are requested to facilitate communication between you and the company and/or its affiliates. E-mail addresses are not sold or furnished to any other entity except as may be required by law or regulatory authority.

**Agreement**

Sign, date and return the Agreement and Commission Schedule.

**Supplement to Agent Agreement for Sales of Products Subject to HIPAA**

Sign, date and return the Supplement.

**Authorization for the Release of Information**

**Authorization Agreement for Automatic Deposits**

**W-9 Form**

All potential agents must complete and submit a W-9 form. If we are paying commissions to your agency, the W-9 must be completed with agency information and tax identification number.

**Copies of Licenses**

Current copies of your resident and non-resident licenses for all states where you or your agency need to be appointed must be attached. If commissions are to be paid to your agency, send a current copy of the agency license along with the copy of your license.

**Copies of Long Term Care Insurance Continuing Education Certificate (If required by state)**

Colorado, California, Illinois, Indiana, Maryland, and Washington require agents to complete LTCI continuing education **prior** to the sale of Long Term Care Insurance.

**Non-Resident Appointment Fees**

Refer to the Non-Resident Appointment Information form for fee information. Fees for all states where you need a non-resident appointment must be included. Make your check payable to **Assurity Life Insurance Company**.

**Credit Card Authorization**

If you would like to charge your appointment fees to your credit card, complete and sign the Credit Card Authorization form and send in with other forms.

**ATTENTION MASSACHUSETTS AGENTS: You must complete Assurity's Massachusetts Long Term Care Insurance Product Training prior to be contracted with Assurity Life Insurance Company. Please submit your request for this information to [ltccontracting@assurity.com](mailto:ltccontracting@assurity.com).**

**NOTE: In doing business with Assurity, you will need to access our extranet site to obtain your commission statements and production reports as Assurity does not mail any commissions or production reports. You will receive more information about this once you have become contracted and appointed with Assurity.**



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**Long Term Care Insurance Appointment Application**

**COMPLETION INSTRUCTIONS**

**Individual Applicants:** Complete sections I, III, IV, V & VI. Must sign and return applicable contracts.

**Corporations:** Complete sections I, II, III, IV, V & VI. All Corporate appointments require that appointment information be submitted on at least one officer concurrent with the Corporation. Must sign and return applicable contracts for agency and Solicitor contracts for officer.

**Solicitor Applicants:** Complete sections I, II, III, IV, V & VI. Must sign and return Solicitor contracts.

**PLEASE PRINT OR TYPE AND RESPOND TO ALL QUESTIONS. DO NOT USE ABBREVIATIONS.**

**I. GENERAL INFORMATION**

Mr.  Mrs.  Ms.  Miss Name \_\_\_\_\_

Social Security # \_\_\_\_\_ Maiden or other name (If applicable) \_\_\_\_\_

Residence Address \_\_\_\_\_ Residence Phone (\_\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_ Business Phone (\_\_\_\_\_) \_\_\_\_\_

Business Address \_\_\_\_\_ Fax Number (\_\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_ Date of Birth \_\_\_\_\_

Email Address\*\* \_\_\_\_\_ Gender (Optional)  M  F

\*\* The e-mail address and other information provided is confidential and will be used for Assurity business purposes only. E-mail addresses are requested to facilitate communication between you and the company and/or its affiliates. E-mail addresses are not sold or furnished to any other entity except as may be required by law or regulatory authority.

Primary mailing address to receive Company Information including Underwriting and Compensation correspondence

Business Address  Residence Address

**II. AGENCY INFORMATION**

Agency Name \_\_\_\_\_

Corporation  Partnership

Tax I.D. # \_\_\_\_\_

List officers and their titles below:

Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

**III. ASSIGNMENT OF COMMISSIONS (Select one option)**

Paid Direct: The commission check is made payable and sent to the agent.

Agency Direct/Solicitor: The commission check is made payable and sent to the Agency listed in Section II.

Agent's Signature \_\_\_\_\_ Date \_\_\_\_\_

**IV. LICENSES**

**You must include current license copies for each state in which you are requesting an appointment. If you are requesting non-resident appointments, you must include the proper appointment fee(s).**

Current Resident License # \_\_\_\_\_ State(s) for Appointment \_\_\_\_\_

\*\*If requesting non-resident Florida appointment, list all counties where appointment is required \_\_\_\_\_



**V. LONG TERM CARE INSURANCE CONTINUING EDUCATION**

**Attention Massachusetts Agents: You must complete Assurity's Massachusetts Long Term Care Insurance Product Training prior to contracting with Assurity Life Insurance Company. Please submit your request for this information to [ltccontracting@assurity.com](mailto:ltccontracting@assurity.com).**

Colorado, California, Illinois, Indiana, Maryland, and Washington require agents to complete LTCI continuing education prior to the sale of Long Term Care Insurance.

Have you completed LTCI continuing education?  Yes  No (Please include a copy of your LTCI continuing education certificate)

**VI. ERRORS AND OMISSIONS COVERAGE**

All Assurity producers must maintain a minimum coverage of \$500,000 for each claim per agent with a maximum \$10,000 deductible.

Do you have Errors and Omissions Coverage?  Yes  No

Please provide the carrier for your Errors and Omissions coverage, the policy number and the name of the insured. \_\_\_\_\_

**VII. QUALIFICATION QUESTIONS**

- 1) Have you lived in a different state or county than your present one within the last 5 years?  Yes  No  
If Yes, please list state/county \_\_\_\_\_
- 2) Have you ever been convicted for any offense or pleaded guilty to any misdemeanor or felony charges or have charges currently pending against you or a business with which you are connected? .....  Yes  No
- 3) Do you currently have a pending bankruptcy or have you ever filed for bankruptcy, been declared bankrupt or insolvent, had your salary garnished?.....  Yes  No
- 4) Are you at the present involved in any litigation or are there any unsatisfied judgments or liens (including state or federal tax liens) against you?.....  Yes  No
- 5) Have you ever had a bond denied, paid out or revoked? .....  Yes  No
- 6) Has any insurance company canceled any contract with you or appointment of you as a sales person for any reason other than non-production of business or at your own request? .....  Yes  No
- 7) Are you indebted to any Insurance Company/Agency/Manager (including debit balance)?  Yes  No
- 8) Have you ever had any complaints against your conduct that resulted in a return of premium to any insured? .....  Yes  No
- 9) Have you ever been fined, suspended, placed on probation, reprimanded, entered into a consent order by any insurance department, the SEC, or any other regulatory authority?  Yes  No
- 10) Have you ever had an insurance and/or securities license refused/suspended/revoked or currently restricted or under investigation by any insurance department, the SEC, or any other regulatory authority?.....  Yes  No
- 11) How many years have you been licensed as an insurance agent? \_\_\_\_\_
- 12) How many companies are you currently contracted with? \_\_\_\_\_

**\*You must attach details and dates for any questions answered Yes above.**

I hereby certify that the statements contained in this Appointment Application are true and correct to the best of my knowledge and belief. I understand that any false statements on this Application may be considered as sufficient cause for rejection of this Application, or for termination if such false statement is discovered subsequently.

I understand and agree that:

- I can solicit business only in states where I am licensed and appointed with Assurity Life Insurance Company.
- I will not solicit business in states that prohibit solicitation prior to my appointment.
- As a general rule, it is not acceptable to make a solicitation anywhere other than the resident state of the applicant.
- I will abide by all written rules and regulations (subject to change at any time) set forth by the Company.

**Agent's Signature**  \_\_\_\_\_ **Date** \_\_\_\_\_

<b>THIS BOX MUST BE COMPLETED</b>	
WHO IS YOUR RECRUITING AGENT? _____	AGENT ID _____



ASSURITY® LIFE INSURANCE COMPANY

SUPPLEMENT TO AGENT AGREEMENT FOR SALES OF PRODUCTS SUBJECT TO HIPAA

Accepted:



By: Signature of Agent or Firm Principal

Print or Type Name and Title Here

<p><b>ASSURITY LIFE INSURANCE COMPANY</b></p> <p>This Agreement is effective _____</p> <p>Approved:</p> <p>_____</p> <p>Company Officer</p>
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This Supplement is between the Agent who signed this Supplement (referred to as "you," "your," and/or "Agent" in this Supplement) and Assurity Life Insurance Company (we will be referred to as "Assurity," "our," "we," "us," and "the Company"). This Supplement amends and is a part of the Agent Agreement that you have with Assurity. The provisions stated in all supplements, commission rules, and schedule of commissions are incorporated into and made a part of this Agreement. Any references herein to "Agreement" refer to this Supplement. This Supplement shall become effective on the date shown above.

1. PRIVACY (REQUIREMENTS RELATING TO PROTECTED HEALTH INFORMATION PURSUANT TO HIPAA).

1.1 Definitions. The following definitions relate to this section only.

- a. Business Associate. "Business Associate" means a person who performs, or assists in the performance of, a function or activity involving the use or disclosure of individually identifiable health information, or any other function or activity regulated by the Privacy Rule.
- b. Individual. "Individual" means the person who is the subject of protected health information, or that person's personal representative in his or her fiduciary capacity.
- c. Individually Identifiable Health Information shall mean information that is a subset of health information, including demographic information collected from an individual, and (i) is created or received by a health care provider, health plan, health care clearinghouse (as those terms are defined in the Privacy Rule), or employer; and (ii) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and (a) identifies the individual, or (b) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
- d. Privacy Rule. "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, as in effect or as amended.
- e. Protected Health Information. "Protected Health Information" shall mean Individually Identifiable Health Information transmitted or maintained in any form or medium that you create or receive from or on behalf of Assurity in the course of fulfilling its obligations under this Agreement. "Protected Health Information" shall not include (i) education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. §1232g, and (ii) records described in 20 U.S.C. §1231g(a)(4)(B)(iv).
- f. Required By Law. "Required By Law" means a mandate contained in law that compels a covered entity to make a use or disclosure of protected health information and that is enforceable in a court of law.
- g. Secretary. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.

1.2 Obligations and Activities.

- a. You, as a Business Associate of Assurity, agree to comply with the duties and requirements placed upon Business Associates by the Privacy Rule or as otherwise Required by Law.
- b. You agree to comply with the policies and procedures of Assurity with respect to Protected Health Information.
- c. You agree to not use or disclose Protected Health Information other than as permitted or required by the Agreement or as Required by Law.
- d. You agree to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.
- e. You agree to mitigate, to the extent practicable, any harmful effect that is known to you of a use or disclosure of Protected Health Information by you in violation of the requirements of this Agreement.
- f. You agree to report to Assurity any use or disclosure of the Protected Health Information not authorized or provided for by this Agreement of which you become aware, within thirty (30) days of becoming aware of such use or disclosure.
- g. You agree to ensure that any person or entity to whom you provide Protected Health Information received from Assurity or the Individual, or created or received by you on behalf of Assurity, agrees to the same restrictions and conditions that apply through this Agreement to you with respect to such information.
- h. You agree to make 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 you on behalf of Assurity available to Assurity, or to the Secretary, within ten (10) days of such request, or as designated by the Secretary, for purposes of the Secretary determining Assurity's compliance with the Privacy Rule.
- i. You shall keep a record of disclosures of Protected Health Information and agree to make information regarding disclosures of Protected Health Information available to Assurity within fifteen (15) days of a request by Assurity. You shall provide, at a minimum, the following information: (i) the date of disclosure; (ii) the name of the entity or person who received the Protected Health Information, and the address of such entity or person, if known; (iii) a brief description of the Protected Health Information disclosed; (iv) a brief statement regarding the purpose and explanation of the basis of such disclosure and (v) the names of all individuals whose Protected Health Information was disclosed.
- j. Within fifteen (15) business days of a request by Assurity, you agree to comply with Assurity's request to accommodate an individual's access to his/her Protected Health Information. In the event an individual contacts you directly about access to Protected Health Information, you will not provide access to the individual but shall forward such request to Assurity within five (5) business days of such contact.

- k. Within fifteen (15) business days of a request by Assurity, you agree to comply with Assurity's request to make amendments to Protected Health Information. You shall promptly incorporate any such amendments into the Protected Health Information. In the event an individual contacts you directly about making amendments to Protected Health Information, you will not make any amendments to the individual's Protected Health Information but shall forward such request to Assurity within five (5) business days of such contact.
- l. You agree to notify Assurity within five (5) business days of your receipt of any request, subpoena, or judicial or administrative order to disclose Protected Health Information. To the extent that Assurity decides to assume responsibility for challenging the validity of such request, subpoena or order, you agree to cooperate fully with Assurity in such challenge.
- m. If a customer terminates his or her relationship with you, or the customer's policy is not renewed or is canceled, you shall return to Assurity, or destroy, all Protected Health Information received from Assurity, or created or received by you from the customer. This provision shall apply to Protected Health Information that is in the possession of your employees, subcontractors, agents or associates. You shall retain no copies of the Protected Health Information.

### 1.3 Permitted Uses and Disclosures.

#### General Use and Disclosure Provisions.

Except as otherwise limited in this Agreement, you may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Assurity as specified in the Agreement provided that such use or disclosure would not violate the Privacy Rule if done by Assurity.

#### Specific Use and Disclosure Provisions

- a. Except as otherwise limited in this Agreement, you may use Protected Health Information for the proper management and administration of your business or to carry out your legal responsibilities.
- b. Except as otherwise limited in this Agreement, you may disclose Protected Health Information for the proper management and administration of your business, provided that disclosures are Required By Law, or you obtain reasonable assurances from the person to whom the information is disclosed that it will remain confidential and 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 you of any instances of which it is aware in which the confidentiality of the information has been breached.
- c. You may use Protected Health Information to report violations of law to Assurity and to appropriate Federal and State authorities, where consistent with the Privacy Rule.

### 1.4 Obligations of Assurity.

To the extent that your use or disclosure of Protected Health Information may be affected, Assurity shall notify you of:

- a. Any limitation(s) in its notice of privacy practices of Assurity;
- b. Any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information.
- c. Any restriction to the use or disclosure of Protected Health Information that Assurity has agreed to.

### 1.5 Termination.

- a. Termination for Cause. Upon Assurity's knowledge of a material breach or violation of the requirements imposed by the Privacy Rule by you, Assurity may either:
- b. Provide an opportunity for you to cure the breach or end the violation and terminate this Agreement if you do not cure the breach or end the violation within the time specified by Assurity;
- c. Immediately terminate this Agreement if you have committed a material breach or violated the Privacy Rule and cure is not possible; or
- d. If neither termination nor cure are feasible, Assurity shall report the violation to the Secretary.

### 1.6 Effect of Termination.

- a. Except as provided in paragraph (2) of this section, upon termination of this Agreement, for any reason, you shall return or destroy all Protected Health Information received from Assurity, or created or received by you on behalf of Assurity. This provision shall apply to Protected Health Information that is in the possession of your employees, subcontractors, agents or associates. You shall retain no copies of the Protected Health Information.
- b. In the event that you determine that returning or destroying the Protected Health Information is infeasible, you shall provide to Assurity notification of the conditions that make return or destruction infeasible. Upon written notice by you to Assurity that return or destruction of Protected Health Information is infeasible, you shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as you maintain such Protected Health Information.

1.7. Indemnification. You hereby agree to indemnify and hold Assurity, its employees, officers and directors harmless from and against any and all liability, payment, loss, cost, expense (including reasonable attorneys' fees and costs), or penalty incurred by Assurity, its employees, officers or directors in connection with any claim, suit, or action asserted against such entity or person resulting from the failure to fulfill any obligation imposed on you by the Privacy Rule by you or your employees, agents or subcontractors.

1.8. Injunction. You hereby agree that Assurity will suffer irreparable damage upon your breach of your obligations under the privacy provisions of this Agreement, and that such damages shall be difficult to quantify. You hereby agree that Assurity may file, and you will not contest, an action for an injunction to enforce such provisions against you, in addition to any other remedy Assurity may have.

1.9. Survival. Your respective rights and obligations relating to the requirements of the Privacy Rule and Protected Health Information shall survive the termination of this Agreement.

1.10. Interpretation. Any ambiguity in this Agreement shall be resolved to permit Assurity to comply with the Privacy Rule.