UNITED HEALTH CARE - GOLDEN RULE

HIRE PACKET

MAKE SURE YOU ATTACH A COPY OF YOUR INSURANCE LICENSE

IF YOU WANT TO BE PAID TO A CORPORATION YOU MUST COMPLETE THE W-9 FORM WITH YOUR CORPORATE EIN#

LICENSING FEE: **$60 FLORIDA**
PLEASE COMPLETE THE CC FORM

PLEASE COMPLETE AND MAIL TO:

INSURANCE MARKETING CONCEPTS, INC.
4782 W. COMMERCIAL BLVD
TAMARAC, FL 33319
866-290-3505
954-739-4133
954-739-4177 FAX
insmarketing@hotmail.com

Application Checklist

*** To prevent a delay in the processing of your application, please read ***

Please review all of the items listed below, along with the notes to assure that all required documents are submitted. I receive a lot of incomplete applications and it delays the processing time until all required documents can be received.

____ Prospective Broker Application signed and dated

____ Profile completed

____ Fair Act Reporting Disclosure completed

____ Assignment of Commission form if applies:
NOTE: *Applies if commission is paid to an agency or Key Broker*
NOTE: *Make sure one of the two boxes on this form is marked*

____ Credit Card Authorization form if applies:
NOTE: *Make sure expiration date is listed on form*

____ Explanation Page
NOTE: *Complete if any legal question on the application is answered 'yes'*
NOTE: *If yes to question 8, submit with the application proof of payments*
NOTE: *If yes to question 9, submit copy of discharge papers or proof of payments*

____ State License

____ Signature Page signed and dated

A UnitedHealthcare Company

PROSPECTIVE BROKER APPLICATION

GRIC Manager/Representative CHERYL PICKETT FAX: 317-715-7375

☐ Independent Broker ☐ Financial Services ☑ Company Name: KEY BROKER F1F19

Complete Name ______ I prefer to be called: ______

Name of Agency or Company F1F19

Business Street Address ______
(Required for Supplies)

Business Mailing Address ______

City ______ County ______ State ______ ZIP ______

Phone (____) ______ Fax (____) ______ E-mail ______

Home Address ______

City ______ County ______ State ______ ZIP ______

Phone (____) ______ Birth Date ______ Gender ______

Social Security No. ______ National Producer No. ______

Length of time in present community______ If less than five years, please provide previous address(es)

Please check the appropriate box.

☐ All commissions are to be paid to me.

☑ All commissions are to be paid to F1F19 AUBREY S NARAINE, 520939B
Agency, Company, or Name — Tax ID No.

Please answer all questions. (If YES, include details of who, what, when, and dollar amounts on an additional form.)

	Question	YES	NO
1.	Have you ever had an appointment terminated by any insurance company or financial services institution (for reasons other than production)?	☐	☐
2.	Do you owe any debt or balance to any insurance company or financial services institution that has remained overdue for more than sixty (60) days?	☐	☐
3.	Has any state or federal agency ever denied, suspended, revoked, or taken any action against any fiduciary license held or applied for by you, or have you ever voluntarily submitted to any sanction or surrendered any fiduciary license under threat of suspension or revocation of that license?	☐	☐
4.	Has any state or federal self-regulatory body of any type (such as National Association of Securities Dealers) ever taken any disciplinary measures against you?	☐	☐
5.	Have you ever had a claim filed against your Errors and Omissions Coverage, or has any bonding company ever denied, paid out on, or revoked a bond for you?	☐	☐
6.	Have you ever been the subject of any civil or administrative proceeding, including one initiated by a state department of insurance?	☐	☐
7	Do you have any felony charges pending against you, or have you ever pled guilty or *nolo contendere* to or been convicted of a felony or a crime involving moral turpitude?	☐	☐
8	Do you have any unsatisfied liens (tax or otherwise) or judgments (civil or otherwise) against you?	☐	☐
9.	Have you been the subject of a bankruptcy petition or proceeding in the past seven (7) years?	☐	☐

(1) I hereby represent that the answers and statements ("the information") I am giving Golden Rule Insurance Company and its affiliates ("the Company") on this application ("PBA") are correct, complete, and wholly true (2) I understand the Company will rely on the information as one factor in considering this PBA, and may, at its option, terminate or rescind our resulting business relationship if any of the information is not as I have given it. (3) I give the Company, its employees, agents, and/or contractors permission to direct advertising or promotional phone calls, faxes, and electronic mail to the numbers and addresses I have listed above, as well as any others I provide. This permission continues until specifically revoked by me in writing. (4) I understand this PBA will not be considered until I sign the FCRA Authorization

Signature (X) ______ Date ______

NOTE: No business may be solicited until all state licensing and appointment and/or contract requirements have been met, and you have been advised of that fact in writing by the Company.

34370-0306

Mar 20 2006 03:01:19 pm

Golden Rule®
A UnitedHealthcare Company

PROFILE INFORMATION

1 How many new individual health applications did you personally write in the past 12 months with all companies combined -- excluding Short Term, Medicare Supplements, and Employer/Group policies? (Check one.)

❑ 0 ❑ 1-3 ❑ 4-7 ❑ 8-11 ❑ 12-20 ❑ 21-50 ❑ 51-100 ❑ 101-200 ❑ 201+

How many do you plan to write in the next year? (Check one.) ❑ More ❑ Same ❑ Less

2 What type of individual health plans do you personally write most often -- excluding Short Term, Medicare Supplements, and Employer/Group policies? (Check one.)

- ❑ Low Deductible Copay Plans -- Plans with $1,000 or lower deductible which include doctor office visit copays
- ❑ High Deductible Copay Plans -- Plans with $1,250 or higher deductible which include doctor office visit copays.
- ❑ Traditional Major Medical Plans -- Major medical plans that do not include doctor office visit copays
- ❑ HSA Plans -- Plans that combine medical insurance with a tax-favored savings account
- ❑ Hospital Surgical Plans -- Lower premium plans which primarily cover major hospital and surgical expenses.
- ❑ Other -- Please specify. ____________________

3 Please put the number 1 by the company you consider to be your primary source for your new individual health applications and a number 2 by your secondary company. Please mark 1 and 2 only.

___ Aetna	___ Anthem Blue Cross/ Blue Shield	___ Golden Rule	___ Pacific Care
___ American Community		___ Humana	___ Unicare
___ American Medical Security	___ Celtic	___ John Alden	___ None
___ American Republic	___ Fortis/Time/Assurant	___ Medical Mutual	___ Other ________

4 In the past 12 months, how many of the following products have you written?

Short Term Medical Plans	Medicare Supplements	Health Savings Accounts (HSAs)
❑ 0	❑ 0	❑ 0
❑ 1-10	❑ 1-10	❑ 1-10
❑ 11-50	❑ 11-50	❑ 11-50
❑ 51+	❑ 51+	❑ 51+

5 Which company's individual short-term medical plan(s) do you write? Please mark 1 and 2 only.

___ American Community	___ Celtic	___ Healthnet	___ None
___ American Family	___ Fortis/Time/Assurant	___ Humana	___ Other ________
___ Anthem Blue Cross/ Blue Shield	___ Golden Rule	___ Trustmark	
	___ GradMed		

6 Which company's Medicare supplement plan(s) do you write? Please mark 1 and 2 only.

___ Anthem Blue Cross/ Blue Shield	___ Continental Life	___ Mutual of Omaha	___ Unicare
	___ Golden Rule	___ Standard Life	___ Other ________

Mar 20 2006 03:01:19 pm

Copyright © 2006 Golden Rule Insurance Company

FAIR CREDIT REPORTING ACT DISCLOSURE and AUTHORIZATION

GOLDEN RULE INSURANCE COMPANY AND ITS AFFILIATED COMPANIES ("THE COMPANY") MAY OBTAIN A CONSUMER REPORT ABOUT YOU IN CONNECTION WITH YOUR PROSPECTIVE BROKER APPLICATION ("PBA")

AUTHORIZATION

I authorize the Company to conduct a public records search, and/or to obtain a consumer report and/or investigative consumer report about me from a consumer reporting agency. These reports may concern my credit history, worthiness, standing, and/or capacity. These reports may also concern my character, general reputation, personal characteristics, mode of living, criminal history, motor vehicle record, and other data relevant to the appointment and/or contract process with the Company. I understand the Company will use this data within that process as one factor in considering my PBA.

I understand that if the Company decides not to approve my PBA, and thereby to take adverse action against me because of information contained in any consumer report(s) authorized by my signature on this form, the Company will provide to me:

- A written pre-adverse action disclosure;
- An adverse action notice;
- A copy of any consumer report(s) received and used by the Company;
- A copy of "A Summary of Your Rights Under the Fair Credit Reporting Act";
- The name, address, and telephone number of any consumer reporting agency that furnished a consumer report about me to them.

I understand that I am entitled to contest the accuracy or completeness of information contained in any consumer report. I understand that I am entitled to receive an additional free copy of any consumer report. I understand that the consumer reporting agency does not itself make any decision regarding my PBA, and the agency cannot explain the Company's decision to me.

A photocopy or fax copy of this authorization shall be as effective as the original. This authoriztion remains valid until I revoke it in writing sent to the Company.

Printed Name: ____________________ Social Security Number: ____________________

(X) Signature: ____________________ Date: ____________________

Home Address: ____

City, State, and ZIP: ____

Golden Rule®
A UnitedHealthcare Company

34370-0306

ASSIGNMENT OF COMMISSIONS AND OTHER COMPENSATION

To: Golden Rule Insurance Company and/or American Medical Security Life Insurance Company and/or Pacificare Health Plan Administrators, Inc., and/or United Healthcare Insurance Company, and/or any affiliated company (collectively, "the Company").

If and when the Company owes me compensation because I have sold or secured the sale of insurance products of the Company or for any other reason, I (the undersigned "Assignor") do not wish to receive that compensation, but instead assign all of the compensation to, and direct the Company to pay all of it to, the person or entity I have written below as Assignee:

PLEASE PRINT AUBREY S. NARAINE 520939B

Assignee Name (person/entity to be paid) Social Security/Tax ID Number

PLEASE PRINT 11 S GUILFORD RD CARMEL, IN 46032 317-848-7622

Street City State ZIP Phone

This Assignment applies to (select ***ONE***):

☐ all first year and renewal compensation; or

■ all compensation attributable to my business written ***after*** the date this form is processed by the Company.

I understand and agree that:

1. Payments made by the Company pursuant to this Assignment fully discharge all of the Company's financial obligations to me under any compensation arrangement between us (individually or collectively the "Contract").

2. This Assignment is subject to, and does not affect, any terms or conditions of the Contract except as specifically provided herein

3. This Assignment is subject to applicable state and federal laws regarding assignment of commissions by insurance producers (by whatever name called). The Company will not be bound by this Assignment in any instance in which it believes applicable law prevents it from paying the Assignee, and it then may pay the person or entity that it, in its sole discretion, determines to be appropriate under the circumstances

4. This Assignment shall remain in effect, and is binding on both myself and the Company, until revoked. I may revoke this Assignment by sending written notice to the Company. Such revocation will only apply to business written after the effective date of the revocation, and this Assignment will remain in effect for business written for the Company prior to that date. Revocation will be effective on the latter of the date I request, or thirty (30) days after the Company's receipt of the notice. Otherwise, this Assignment is automatically revoked concurrently with termination of the Contract for cause, or upon commencement of any proceeding in bankruptcy, liquidation, receivership or dissolution by or against me or my listed Assignee

5. This Assignment does not apply to merchandise, trips or other non-cash incentives, awards, contests or other remuneration (collectively "prizes") that the Company may offer from time to time. It also does not apply to a cash equivalent in the event either I or the Company choose to remit or accept such cash equivalent in lieu any particular prize.

(X) ______________________ Assignor Signature

______________________ Date Signed

______________________ Assignor Printed Name

______________________ Social Security/Tax ID Number

Appointment Fee Credit Card Authorization Form

Producer's NPN (National Producer Number) (If known): ______________________

I authorize Golden Rule to bill my VISA/MASTERCARD account.

☐ VISA ☐ MASTERCARD Exp. Date: ______/______ Amount Charged: ☐☐☐☐☐☐

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

X______________________________ ______________________________

Printed Name (Please print legibly) Telephone Number *Required*

X______________________________

Signature of Cardholder

NOTE: Your resident appointment fee is refundable upon the submission of your first application.

Payment is for: (Please check one)
☐ Appointment Fee
☐ Renewal Fee
☐ Charge Back

State Resident and Nonresident Appointment Fees

If payment is for appointment fee(s), please indicate the state and fee(s) to be charged.

These fees are charged by each state's department of insurance and are subject to change.

State	Resident	Non-resident	State	Resident	Non-resident
Alabama	☐ $30	☐ $30	Missouri	☐ No Fee	☐ No Fee
Alaska	☐ No Fee	☐ No Fee	Montana	☐ No Fee	☐ No Fee
Arizona	☐ N/A	☐ N/A	Nebraska	☐ $8	☐ $8
Arkansas	☐ Fee Paid*	☐ Fee Paid*	New Hampshire	☐ $25/Agency $25	☐ $25/Agency $25
California	☐ $24/Agency $24	☐ $24/Agency $24	New Jersey	☐ $25/Agency $25	☐ $25/Agency $25
Colorado	☐ N/A	☐ N/A	New Mexico	☐ $23	☐ $23
Connecticut	☐ No Fee	☐ No Fee	Nevada	☐ $15/Agency $15	☐ $15/Agency $15
Delaware	☐ $25	☐ $25	North Carolina	☐ $40 + $10**	☐ $40 + $10**
District of Columbia	☐ $25/Agency $25	☐ $25/Agency $25	North Dakota	☐ $10/Agency $10	☐ $10/Agency $10
Florida	☐ $60	☐ $60***	Ohio	☐ $20/Agency $20	☐ $20/Agency $20
Georgia	☐ $10	☐ $10	Oklahoma	☐ $40/Agency $40	☐ $40/Agency $40
Hawaii	☐ No Fee	☐ No Fee	Oregon	☐ No Fee	☐ No Fee
Idaho	☐ No Fee	☐ No Fee	Pennsylvania	☐ $15/Agency $15	☐ $15/Agency $15
Illinois	☐ N/A	☐ N/A	Rhode Island	☐ N/A	☐ N/A
Indiana	☐ N/A	☐ N/A	South Carolina	☐ Fee Paid*	☐ Fee Paid*
Iowa	☐ No Fee	☐ No Fee	South Dakota	☐ $10/Agency $10	☐ $20/Agency $20
Kansas	☐ $5/Agency $5	☐ $5/Agency $5	Tennessee	☐ $15	☐ $15
Kentucky	☐ $40/Agency $100	☐ $50/Agency $120	Texas	☐ $10/Agency $10	☐ $10/Agency $10
Louisiana	☐ $20/Agency $20	☐ $20/Agency $20	Utah	☐ No Fee	☐ No Fee
Maine	☐ $30/Agency $30	☐ $70/Agency $70	Vermont	☐ $60	☐ $60
Maryland	☐ N/A	☐ N/A	Virginia	☐ $12/Agency $12	☐ $12/Agency $12
Massachusetts	☐ $75/Agency $75	☐ $75/Agency $75	Washington	☐ $20/Agency $20	☐ $20/Agency $20
Michigan	☐ $5/Agency $5	☐ $5/Agency $5	West Virginia	☐ $25	☐ $25
Minnesota	☐ $10	☐ $10	Wisconsin	☐ $7	☐ $24
Mississippi	☐ $25	☐ $25	Wyoming	☐ $15/Agency $15	☐ $15/Agency $15

* Fee paid by appointing insurance company.
** Add $10 for Med Supp/LTC appointment.
*** Add $6 per Florida county.

PBA Explanation Page

This page is required for any of the questions that have a "yes" answer on the Prospective Broker Application. A detailed explanation is needed and should include who was involved, when it occurred, dollar amounts, detailed information as why it occurred and steps taken to resolve issue

Producer Name: ______________________

Producer number: ______________________

Question # ________

____

____

____

____

____

____

____

____

____

____

____

(X) ______________________ ______________________

Producer Signature Date

Mar 12 2007 10:36:16

348224303

Sign and Return this Page to Golden Rule

INDEPENDENT BROKER'S CONTRACT
SIGNATURE PAGE

I acknowledge and agree that:

(a) I have received a copy of the Independent Broker's Contract (IBC-0405), consisting of this page and four (4) other pages, as well as the Rules and Regulations (Rules-0405), which are fully incorporated by reference and made a part of the *Contract*;

(b) I have read, understood, and agreed to each and every term of this *Contract*; and

(c) This *Contract* will not be in effect until such time as the *Company* has countersigned this Signature Page and attached the appropriate *Commission Schedule*(s).

YOU: ______________________________ **BY:** ______________________________
Print or type *Your* Name — Print Name (and title if signing in a representative capacity)

X ______________________________ ______________________________
Signature — Date

BENEFICIARY DESIGNATIONS (See 3.9): Name Address Relationship

Primary Beneficiary(ies):

____

____

Contingent Beneficiary(ies):

____

____

FOR HOME OFFICE USE ONLY
EXECUTED ON BEHALF OF GOLDEN RULE INSURANCE COMPANY

BY: ______________________________
Name

X ______________________________
Signature — Date

This agreement shall take effect as of ______________ **Producer No.** ______________

Apr 29 2008 04:09:02

SUB-BROKER CONTRACT CHANGE REQUEST/ASSIGNMENT FORM

Subject to acceptance by UnitedHealthcare, or any of its affiliates, please change my existing contract with UnitedHealthcare to show I am a sub-broker under the Key Broker contract between AUBREY S NARAINE and UnitedHealthcare
Key Broker

- [ ] Pay Commissions directly to me, and the override to the Key Broker.
- [ ] Pay Commissions to agency tax id # ________ and the override to the Key Broker.
- [x] Pay Commissions directly to the Key Broker.

Agreed and accepted:

Must be completed by the Sub-Broker

Sub-Broker:

X
Sub-Broker Signature

Printed Name

Producer Number

Date

Address

City St Zip

Must be completed by the Key Broker/Principal

Key Broker: Aubrey Naraine
By:

X
Authorized Signatory of Agency

Printed Name

Tax ID Number 520939B **Agency Code** F1F19

Date

Address 115 GUILFORD RD CARMEL IN 46032-1531

City CARMEL St IN Zip 46032

Do you authorize this Sub-Broker to be advanced?
- [ ] Yes
- [x] No

Accepted by UnitedHealthcare:

Golden Rule National Key Broker Sales Manager

Date

Effective Date:

Brokers that have written more than 2 individual health applications with UnitedHealthcare in the last 6 months are not eligible to transfer.

GOLDEN RULE USE ONLY			
KB Status	KB # of Subs	KB # of Subs Allowed	KB Past 12mth Prod
Broker past 6mth Prod	Current Agency Code	Appointment Date	