Healthy America Insurance Agency, Inc
409 W Vickery Blvd
Fort Worth, TX 76104
Toll Free (800) 964-8331
Fax (817) 335-1270
healthyamericainsurance.com
ubamembers.com
licensing@healthyamericainsurance.com

ASSOCIATE AGREEMENT

WE WELCOME YOU AS A MEMBER OF THE HEALTHY AMERICA TEAM.

APPLICANT INFORMATION

Social Security Number of Applicant

Birthdate (Required)

Company FEIN Number

Applicant Name (Last, First, M.I.)

Company Name (Optional)

Sponsor
NHPA4582- National Health Plans & Benefit

Commission Advance ☐ YES ☐ NO

Address

Daytime Phone Number

City | State | Zip

Evening Phone Number

Email Address

FAX Number

Note: Must have applicant Social Security Number. Regardless if seeking to get agency appointed. Cannot appoint agency with out agency being licensed in the states for sales.

DIRECT DEPOSIT INFO

Name on Account

Bank Account No.

Bank Routing No.

Signature

☐ Checking ☐ Savings

I authorize Healthy America Insurance Agency, Inc. to deposit my payroll automatically to the account indicated below and, if necessary, to adjust or reverse a deposit for any payroll entry made to my account in error. This authorization will remain in effect until I cancel it in writing and in such time as to afford Healthy America Insurance Agency, Inc. a reasonable opportunity to act on it.

INSURANCE LICENSED REQUIRED

The following questions MUST be answered, or the application will be returned:

1. Has your insurance license, from any state, ever been suspended or revoked? ☐ Yes ☐ No
2. Have you ever been convicted of a felony? ☐ Yes ☐ No
3. Have you ever declared any form of bankruptcy? ☐ Yes ☐ No
   If yes, submit details.

Resident State: License #:

Non-Resident State Appointments (please list states):

LICENSING REQUIREMENT CHECKLIST

- ☐ Information Questionnaire (This sheet)
- ☐ Copy of Licenses or NIPR report for current licenses
- ☐ Crum & Forster Appointment Paperwork (separate form) *must also be signed and completely filled out*
- ☐ W-9 Form (separate form)
- ☐ Chubb Appointment Paperwork (separate form) *must be completed to sell Gap HCI Plan*

I hereby acknowledge that I have received a copy of the Associate Agreement. I commit to uphold the spirit of intent and values contained herein. I have read, understood, and agree to abide by the Associate Agreement of Healthy America Insurance Agency, Inc.

I certify that the foregoing statements are true and correct to the best of my knowledge and belief. I hereby grant any licensed agent or employee of Healthy America or a company for which Healthy America acts as general agent or wholesaler, permission to receive this Application and to verify such answers. I understand that any false statements on this application may be considered as sufficient cause for rejection, or for termination if such false statements are discovered subsequent to acceptance. If accepted, I agree to comply with all rules and regulations of the State Department of Insurance. All solicitation methods, either personally or by third party vendors must comply with applicable state & federal laws. I understand that any fees paid here are not refundable in any event.

APPLICANT'S SIGNATURE DATE

Form **W-9**
(Rev. January 2011)
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 (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification (required): ☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

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

☐ Other (see instructions) ▶

☐ Exempt payee

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

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

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

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

			–		–				

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).

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 ▶**

General Instructions

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

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.

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. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

POLICIES & PROCEDURES

In accordance with the terms and conditions contained in this Application and Agreement (hereinafter "Agreement"), I hereby submit my application to become an Associate, (hereinafter referred to as "Associate"), with Healthy America Insurance Agency, Inc., (hereinafter referred to as "Healthy America"), and hereby state and agree as follows:

1. I am of legal age, in the state in which I reside, to enter into this Agreement. This Agreement becomes effective on the date received, signed by the applicant, and accepted by Healthy America in its home office located at 409 W Vickery Blvd, Fort Worth, Texas 76104.
2. Upon acceptance of this application I understand I will become an Associate of the Company and will be eligible to participate in the selling of Healthy America's services and receive commissions in connection with such sales in accordance with Healthy Ameica's Policies & Procedures & Compensation Plan.
3. I understand that as an Associate, I am an independent contractor, not an agent, employee or franchisee of Healthy America. I further understand & agree that I will not be treated as an employee with respect to such services, for federal or state tax purposes. Nor will I be treated as an employee for purposes of the Federal Unemployment Tax Act, and Federal Insurance Contributions Act, the Social Security Act, and State Unemployment Act or State Employment Security Act. I understand and agree to pay all applicable federal and state income taxes, self employment taxes, sales taxes, local taxes, and/or local license fees that may become due as a result of my activities under this Agreement.
4. I agree that as an independent contractor, I will be solely responsible for all statements made regarding Healthy America's Compensation Plan or services which are not expressly contained in writing in Healthy America's policies, product description or Compensation Plan.
5. I understand and agree that my remuneration will consist solely of commissions, overrides and/or bonuses, relating to the sale or other output derived from in person sales, solicitations or orders from ultimate consumers, primarily in the home or otherwise, rather than in a permanent retail establishment.
6. I understand that I am not required to make any purchase in order to become an Associate. If I decide not to continue as an Associate, I may submit my written notarized resignation. Doing so automatically terminates this Agreement. I understand I am not required to purchase inventory of any kind in order to become an Associate.
7. I hereby agree to represent Healthy America's Compensation Plan fairly & completely, emphasizing that retail sales are a requirement, that no purchase of goods or services is required at any level, that no recruitment fee can be derived from the mere act of sponsoring other Associates, and that no earnings are guaranteed from participation in the Compensation Plan. I agree that I will not make any representations about the actual, potential or expected earnings of any Associate of Healthy America.
8. I understand that as an Associate, I am not guaranteed any income, nor am I assured any profit or success. I understand the Compensation Plan and that I can only make commissions upon the sale of Healthy America's goods and services. I will be free to set my own hours, and determine my own location and methods of selling, within the guidelines and requirements of this Agreement.
9. I further certify that neither Healthy America nor my sponsor have made any claims of guaranteed earnings or representations of the anticipated earnings that might result from my efforts as an Associate. I understand that my success as an Associate comes from retail sales, service, and the development of a marketing organization. I understand and agree that I will make no statements, disclosures, or representations in selling Healthy America's goods & services or in the sponsoring of other prospective Associates other than those contained in approved company literature.
10. I hereby agree not to re-package or re-label Healthy America's services nor to sell said services under any other name or label. I further agree to refrain from producing, selling, and using, for the purpose of advertising, promoting or describing Healthy America's services, Compensation Plan, or other programs, any written, recorded, or other materials which have not been approved or provided by Healthy America.
11. In the event I sponsor other Associates, I agree to perform a bonafide supervisory, distributive and selling function in connection with the sale of Healthy America's services to the ultimate consumer. I also agree to train any Associates I may sponsor in the performance of these functions. I agree to have continuing communication and supervision with my sales organization.
12. I understand and agree that Healthy America, in order to maintain a viable marketing system, may make modifications in the Policies and Procedures, Compensation Plan, company literature and product prices. I further agree to be bound by such changes upon notification through official company literature.
13. I understand that the acceptance of this Application does not constitute the sales of a franchise or a distributorship, and that there are no exclusive territories granted to anyone, and that no franchise fees have been paid, nor am I acquiring any interest in a security by the acceptance of this Agreement.
14. I understand and agree that because of the personal nature of this Agreement it may not be transferred or otherwise assigned without the prior written consent of Healthy America.
15. Healthy America reserves the right at any time to no longer accept new membership sales or associate recruitments from any Associate, and to adjust or change any marketing plan and incentive program and to modify these Policies and Procedures at any time without prior notice.
16. This Associate Agreement may be terminated at any time upon written notice by the Associate, by Healthy America Insurance Agency, Inc.. with written notice to the Associate, immediately by Healthy America Insurance Agency, Inc. for actions or statements which Healthy America, in its sole discretion, determines to be contrary to its best interests. An Associate who terminates his/her Associate Agreement or who is terminated by Healthy America will, effective on the date of termination, no longer be entitled to any bonuses or commissions, including renewals, advanced or earned, personal or downline.
17. Following the conclusion of the original Associate Application, which is subject to renewal January 1st of each year, the Associate may renew, as long as all Associate obligations are fulfilled. New Applications that are received and accepted by Healthy America after September 1st are not subject to the renewal requirement on January 1st of the year immediately following. The Associate who fails to renew his or her Distributorship at the end of each fiscal year will result in expiration of that Distributorship, and all rights to rebates, bonuses, position, and wholesale purchase authority shall cease. An Associate whose Distributorship expires, is not entitled to receive any sales commissions, override commissions, bonuses or any other remuneration, past the expiration date of the Distributorship.
18. This Agreement is governed by the laws of the State of Texas and the parties agree that any claim dispute or other difference between them shall be exclusively resolved by binding arbitration pursuant to the Commercial Arbitration Rules of the American Arbitration Association with arbitration to occur at Healthy America's preference in Fort Worth, Texas. This Agreement shall be binding upon the successors and assigns of both parties.
19. I understand and agree that this Agreement, including Healthy America's Policies & Procedures, & Compensation Plan, incorporated herein by reference, constitute the entire agreement between the parties hereto.

A PARTICIPANT IN THIS COMPENSATION PLAN HAS A RIGHT TO CANCEL AT ANY TIME, REGARDLESS OF REASON. CANCELLATION MUST BE SUBMITTED IN WRITING TO HEALTHY AMERICA INSURANCE AGENCY, INC. AT ITS PRINCIPLE PLACE OF BUSINESS.

CRUM & FORSTER
A FAIRFAX COMPANY

Last Name	*First Name*	*Middle*

Social Security Number	*Date of Birth*

Agency Name	*Tax ID#*

Resident Address	*City*	*State*	*Zip*

Business Address	*City*	*State*	*Zip*

Business Phone	*Cell Phone*	*Fax Number*

Email	*Website*

Agent's Signature	*Date:*

Preferred Mailing Address ☐ *Business* ☐ *Resident*

Please check off the states below, in which you will be representing Crum & Forster. Will you be assigning commissions to the agency or corporation named above? Yes ☐ *No* ☐

☐	AL	☐	AK	☐	AZ	☐	AR	☐	CA	☐	CO	☐	CT	☐	DE
☐	DC	☐	FL	☐	GA	☐	HI	☐	ID	☐	IL	☐	IN	☐	IA
☐	KS	☐	KY	☐	LA	☐	ME	☐	MD	☐	MA	☐	MI	☐	MN
☐	MS	☐	MO	☐	MT	☐	NE	☐	NV	☐	NH	☐	NJ	☐	NM
☐	NY	☐	NC	☐	ND	☐	OH	☐	OK	☐	OR	☐	PA	☐	RI
☐	SC	☐	SD	☐	TN	☐	TX	☐	UT	☐	VT	☐	VA	☐	WA
☐	WV	☐	WI	☐	WY										

Notice Regarding Background Checks

*Before our company may begin processing your appointment and/or license application, we are required by *federal law to ensure that all agents and/or employees we wish to do business with are not convicted criminals or felons. *(Criminal checks are based on the Violent Crime Control Act of 1994)*

Please respond to the following questions:

Have you ever been convicted of a been convicted of a felony, had a judgment withheld or deferred, or are you currently charged with committing a felony, or convicted of a misdemeanor, had a judgment withheld or deferred, or are you currently charged with committing a misdemeanor? Yes☐ No☐ If yes, provide an explanation

For Office Use Only – To be completed by C&F Underwriter authorizing the above appointment request.

Underwriter's Name	*Underwriter's Signature*

Crum & Forster Relationship ☐ Master Agent ☐ Sub-agent ☐ Other (please explain below)

Appointment requested for ☐ Accident and Health ☐ Property and Casualty ☐ Limited Lines Travel

Appointing Company ☐ US Fire Insurance Company ☐ The North River Insurance Company

Underwriter's Comments

Email to: licensing@healthyamerica.biz

Or Fax to: 817.335.1270

Chubb – SUB PRODUCER APPOINTMENT REQUEST
LICENSING INFORMATION FORM

AGENCY NAME: _HEALTHY AMERICA INSURANCE AGENCY INC_ Master/Producer Code: ___Z05991_____

☐ Appointment ☐ New Appointment ☐ Change ☐ Termination ☐ Reinstatement

Effective Date (Current Date)_____ Termination Date:_____

Companies:
■ Federal Insurance Company
☐ ACE American Insurance Company
☐ Other_____

SUB-PRODUCER INFORMATION

Full Legal Name of Agency/Broker (As shown on license) of sub-producer:

_____

_____

Street Address:_____

_____

Organization Type: ☐Corporation ☐Partnership
☐Individual ☐Sole Proprietorship

Tax ID or Social Security Number:_____

Contact Person at Producer's office to provide licensing information:

Name:_____ Phone Number:( )_____

e-mail address: _____

CHECK ALL STATES WHERE APPOINTMENTS NEEDED AND PROGRAM APPROVED

STATES TO BE APPOINTED									
	☐ AL	☐ AK	☐ AZ	☐ AR	☐ CA	☐ CO	☐ CT	☐ DE	☐ DC
	☐ FL	☐ GA	☐ HI	☐ ID	☐ IL	☐ IN	☐ IA	☐ KS	☐ KY
	☐ LA	☐ ME	☐ MD	☐ MA	☐ MI	☐ MN	☐ MS	☐ MO	☐ MT
	☐ NE	☐ NV	☐ NH	☐ NJ	☐ NM	☐ NY	☐ NC	☐ ND	☐ OH
	☐ OK	☐ OR	☐ PA	☐ RI	☐ SC	☐ SD	☐ TN	☐ TX	☐ UT
	☐ VT	☐ VA	☐ WA	☐ WV	☐ WI	☐ WY			

Program approved states: AL, AR, AZ, CA, DE, FL, GA, IL, IN, IA, KY, MI, MS, NV, NM, NC, ND, OH, OK, PA, RI, SC, TN, TX, VA, WI and WY

Form Completed By: Name:_____ Date:_____ Phone:_____

Processed by Producer Licensing (Chubb): Name:_____ Date:_____

LICENSEE INFORMATION	
INDIVIDUAL LICENSE DATA NEEDED	**INDIVIDUAL 1**
NAME (EXACTLY AS LICENSED)	
RESIDENCE ADDRESS	
DATE OF BIRTH - Required	
SOCIAL SECURITY NUMBER - Required	
TITLE IN AGENCY	
STATE(S) TO BE APPOINTED	
NPN NUMBER:	
INDIVIDUAL LICENSE DATA NEEDED	**INDIVIDUAL 2**
NAME (EXACTLY AS LICENSED)	
RESIDENCE ADDRESS	
DATE OF BIRTH	
SOCIAL SECURITY NUMBER	
TITLE IN AGENCY	
STATE(S) TO BE APPOINTED	
NPN NUMBER:	
INDIVIDUAL LICENSE DATA NEEDED	**INDIVIDUAL3**
NAME (EXACTLY AS LICENSED)	
RESIDENCE ADDRESS	
DATE OF BIRTH	
SOCIAL SECURITY NUMBER	
TITLE IN AGENCY	
STATE(S) TO BE APPOINTED	
NPN NUMBER:	
INDIVIDUAL LICENSE DATA NEEDED	**INDIVIDUAL 4**
NAME (EXACTLY AS LICENSED)	
RESIDENCE ADDRESS	
DATE OF BIRTH	
SOCIAL SECURITY NUMBER	
TITLE IN AGENCY	
STATE(S) TO BE APPOINTED	
NPN NUMBER:	

Assignment of Commissions

I hereby, understand that all of my commissions for my submitted applications will be paid to

National Health Plans & Benefits .

(Company Name)

Also, I understand that said company above will be paying all commissions to me instead of being paid directly by Healthy America.

I further note that all inquiries regarding commissions will be directed to said company above only and will not hold Healthy America responsible.

_____

Agent Signature

_____

Date