HEALTHSPRING
More from Medicare. More from life.

Greetings from HealthSpring

Thank you for your interest in becoming a selling partner with HealthSpring and/or Bravo Health, a HealthSpring Company. Based in Nashville, Tennessee, HealthSpring got its start in 2000 and is now one of the country's largest and fastest-growing coordinated care plans whose primary focus is Medicare Advantage plans. HealthSpring currently owns and operates Medicare Advantage plans in Alabama, Delaware, Florida, Georgia, Illinois, Maryland, Mississippi, New Jersey, Pennsylvania, Tennessee, Texas, and Washington, D.C. We are dedicated to improving the health of the communities we serve by delivering the highest quality and greatest value in healthcare benefits and services and look forward to welcoming you to our team.

What happens next?

Your first step in the on-boarding process will be to complete any necessary contracting paperwork. Please refer to the "Contracting Checklist" found in your contracting kit as a tool to help guide you through this process.

Upon completing contracting you will receive an email providing you instruction on how to access and complete the required AHIP exam. Because we greatly value our agents, we offer the AHIP exam at the discounted price of $100.00 when the exam is taken through our site www.medicareonlinetraining.com/healthspring.

Once you have passed AHIP, you will be directed to complete the following modules for 2012 certification: FWA, HIPAA, Selling with Integrity and Compliance training. Once all of these additional courses have been completed, please schedule your face-to-face training in your local market. This is the last step in your certification process as the training will then be processed by Corporate Sales Operations and you will receive a writing number and welcome email in the days after. Please make sure not to begin marketing our plans until you have received your welcome notification email or letter.

If you have any questions or need assistance in any part of the on-boarding process, please do not hesitate to contact Sales Operations by way of the contracting mailbox at contracting.mailbox@healthspring.com, and we will be happy to assist you.

Good luck in completing this process and we look forward to welcoming you to our team.

Thank you!

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Sub Agent Contracting Checklist:

☐ **Copies of valid licensing for each market in which you intend to sell**

☐ **A copy of your E&O policy/coverage**

☐ **Hierarchy Form**
Please list the name of your agency on the GA or FMO line

☐ **W-9**

☐ **Assignment of Commissions Form**
Complete this form if you will be assigning your commissions to your agency

☐ **ACH Form**
Complete this form if you would like Direct Deposit; if not, you will be mailed a check

☐ **Agent Application**
All 3 pages filled out in their entirety

☐ **HealthSpring Release Authorization and Fair Credit Reporting Act Disclosure**
This form gives us permission to perform your background check

☐ **Sales Representative Addendum**

☐ **Agent Acknowledgement & P&P Sign-off Form**

Once paperwork is complete, please fax to 410-537-8959 or email to contracting.mailbox@healthspring.com

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Hierarchy Form

Agent Name ______________________________

GA Name ______________________________

MGA Name ______________________________

SGA Name ______________________________

FMO Name ______________________________

☐ Agent assigns commissions to an agency
☐ Agent paid directly by HealthSpring

By signing this, Acknowledgement Form I, __________________________ confirm that I have received HealthSpring corporate Sales policies and procedures and will abide by all of the requirements set forth above. I also attest that I have read them completely and thoroughly, understand them to the fullest extent, and agree to abide by the guidelines they establish. If at any time I am unclear about a policy or have a question I will consult my Sales Manager/Sales Lead for further guidance.

_________________________________ _________________

Employed/Contracted Agent Date

_________________________________ _________________

Sales Manager/Sales Lead Date

agreement with HealthSpring. Agents and other entities in the FMO/SGA/MGA/GA Hierarchy are permitted to changes sales hierarchies no more than once per calendar year. In the event any piece of FMO/SGA/MGA/GA "downline" (as described below) sales hierarchy is terminated or ceases to exist for any reason whatsoever, those legal entities or Agents that are "downline" from such entity may change hierarchies upon at least ten (10) business days written notice to HealthSpring.

In addition, Agents or any other entity in the FMO/SGA/MGA/GA Hierarchy may change sales hierarchy at any time upon written mutual agreement with such Agent's or other entity's direct "upline" piece of the applicable FMO/SGA/MGA/GA Hierarchy. FMO/SGA/MGA/GA consent to such change is not required. Any HealthSpring business and commission payments associated with the Agent or other entity in the FMO/SGA/MGA/GA Hierarchy will automatically move with such Agent or other entity to the new sales hierarchy they/it joins.

- **Commissions – Individual Sales**

Enrollments must be a result of the <u>direct</u> <u>contact</u> between the FMO/SGA/MGA/GA, Broker or Agent and the individual prospect. HealthSpring will pay a commission for each individual whom FMO/SGA/MGA/GA, Broker or Agent enroll in a HealthSpring Medicare Advantage Plan. Commissions are paid per the current commission schedule set forth in Exhibit A. The allocated portion of the commission payments will be paid directly to the FMO/SGA/MGA/GA and Agent of Record during the normal commission payment schedule as set forth by HealthSpring policy unless otherwise agreed between the parties.

By: ______________________________________

Print Name: _______________________________

Date: _____________________________________

HealthSpring

RELEASE AUTHORIZATION AND
FAIR CREDIT REPORTING ACT DISCLOSURE

The applicant for contracting acknowledges that this company may now, or at any time while contracted, verify information within the contract. In the event that information from the report is utilized in whole or in part in making an adverse decision, before making the adverse decision, we will provide to you a copy of the consumer report and a description in writing of your rights under the Fair Credit Reporting Act,15 U.S.C. § 1681 et seq.

Please be advised that we may also obtain an investigative consumer report including information as to your character, general reputation, personal characteristics, and mode of living. This information may be obtained by contacting your present and previous employers or references supplied by you. Please be advised that you have the right to request, in writing, within a reasonable time, that we make a complete and accurate disclosure of the nature and scope of the investigation requested.

Additional information concerning the Fair Credit Reporting Act, 15 U.S.C. § 1681 et seq., is available at the Federal Trade Commission's web site (http://www.ftc.gov).

By signing below, I hereby authorize all entities having information about me, including present and former employers, personal references, criminal justice agencies, departments of motor vehicles, schools, licensing agencies, and credit reporting agencies, to release such information to the company or any of its affiliates or carriers. I acknowledge and agree that this Release and Authorization shall remain valid and in effect during the term of my contract.

You may also be asked to adhere to a random drug test at which HealthSpring has the right to initiate, subject to state notification provisions.

For California*, Minnesota, and Oklahoma Applicants Only: *A consumer credit report will be obtained through Business Information Group, Inc., P.O. Box 541, Southampton, PA, 18966..*

*If an **investigative consumer report** and/or consumer report is processed, I understand that I am entitled to receive a copy. I have indicated below whether I would like a copy. Yes ______ No______*

Initials Initials

Date: ______________________________ Signature of Applicant: ____

Print Name: ____

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Contact information

All information is required to complete contracting

Last Name, first name, middle initial | Date of Birth | Social Security Number

Address | City | State | Zip Code

( ) Phone | ( ) Cell Phone | ( ) Fax Number | E-mail Address

Please list all websites and/or website affiliations:

Provider business office locations for last five years:

Business address	City	State	ZIP Code	From	To
Business address	City	State	ZIP Code	From	To
Business address	City	State	ZIP Code	From	To

Professional designation:

Type of professional designation	From	To
Type of professional designation	From	To
Type of professional designation	From	To

List any insurance agency affiliations for the past five years:

Name of agency	City where agency is located	From	To
Name of agency	City where agency is located	From	To

Please indicate the service area(s) in which you plan to sell HealthSpring (please select all that apply):
*(You **MUST** have a currently active state Health license in all of the states for the service areas you selected below)*

☐ **Texas**	☐ **District of Columbia**
☐ **Pennsylvania**	☐ **Tennessee**
☐ **Maryland**	☐ **Alabama**
☐ **Delaware**	☐ **Illinois**
☐ **New Jersey**	☐ **Mississippi**
☐ **Georgia**	☐ **Florida**

Additional information:

If an answer to any of the following questions is "yes," attach details on separate sheet of paper.

	Yes	No
A. Has your license to sell insurance or HMO Products ever been denied, suspended or revoked by any state?	☐	☐
B. Have any complaints been filed against you with the State Department of Insurance or any other insurance regulatory board or agency within the last five years?	☐	☐
C. Have you ever been denied appointment or renewal appointment by any insurance and/or managed care company?	☐	☐
D. Have you ever been party to a lawsuit relating to the insurance or managed care industry? 1. Have any settlements ever been made on your behalf? 2. Are there any claims or cases presently filed or pending against you?	☐	☐
E. Have you ever filed for bankruptcy?	☐	☐
F. Have you ever been convicted or are you currently being charged or under investigation for any violation of the law other than minor traffic violations?	☐	☐
G. Are any legal actions pending against you by any employer, client, former associate, partner, state board of insurance, law enforcement agency or professional group or organization?	☐	☐

H. How long have you sold individual and/or group HMO products? ______________________________

I. How long have you been in the insurance business? ______________________________

J. Do you speak any foreign language?
If yes, indicate language(s):

____

I certify that the above statements are true and complete and no misrepresentations are contained with the application or attachments.

______________________________ ______________
Signature *Date*

Active appointments with insurance and/or managed care companies:

			HMO Yes	HMO No	PPO Yes	PPO No	Life Yes	Life No
Company name	From	To	☐	☐	☐	☐	☐	☐
Company name	From	To	☐	☐	☐	☐	☐	☐
Company name	From	To	☐	☐	☐	☐	☐	☐
Company name	From	To	☐	☐	☐	☐	☐	☐

Authorization and release:

I understand that HealthSpring Inc. will verify that information in this application and I hereby authorize HealthSpring Inc. or its representatives to contact and obtain information references in this application from an individual present or former client, insurer, corporation or other business entity, regulatory or licensing agency, or state, city or federal agency.

By applying for appointment with HealthSpring Inc., I extend absolute immunity to, and release and hold harmless from any and all liability: (i) HealthSpring Inc., its representatives, employees, trustees, directors, and officers; (ii) any individual, present or former client, insurer, corporation, or other business entity, regulatory or licensing agency, or state, city or federal agency providing information, their representatives, employees, trustees, directors and officers; (iii) any third party for any acts, communications, reports, records, statements, documents, recommendations or disclosures involving me, requested or received by HealthSpring Inc. and its representatives to, from, or by any third party, including otherwise privileged or confidential information.

I certify that the above statements are true and complete and no misrepresentations are contained within the application or attachments.

_______________________ _______________________ _______________________

Name (please print) *Signature* *Date*

Application for appointment includes:

- Completed application, with signature on authorization and release above
- Copy of Current State License(s)

Return completed application along with required documents to:

Corporate Contracting
Contracting.mailbox@healthspring.com
Fax: 410-537-8959
Attn: Corporate Sales Operations
3601 O'Donnell Street
Baltimore, MD 21224

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HealthSpring
Assignment of Commissions

To ______________________________________ Tax ID__________________________
(Legal entity that Commissions are being assigned to, hereinafter the "Assignee")

Assignee's Address____

City________________________________ State_____ Zip Code_____________________

Telephone ________________________________

For valuable consideration, the undersigned, herein called the Assignor, hereby assigns to the Assignee all of the Assignor's right, title, interest, claim or demand in and to any and all compensation now due and payable, or which may become due and payable, under existing contracts and agreements heretofore entered into by and between HealthSpring, Inc. (the "Company") and Assignor.

Assignor hereby authorizes and empowers the Company to pay Assignee all compensation (including but not limited to over-riding commissions) now due or which may become due under the Agreement until such time as Assignor terminates this assignment by written notice to the Company. Assignor acknowledges and agrees that such payment of compensation to Assignee shall constitute payment of such compensation to the Assignor as if paid directly to the Assignor and the Company shall be fully released from any and all responsibility to the Assignor for such payments. Assignor hereby acknowledges and agrees that assignment of compensation payable under the agreement does not release or otherwise relieve Assignor of any obligation or responsibility under the Agreement including, but not limited to, the obligation to pay commissions to any applicable "downline" sales hierarchy and/or the obligation to reimburse the Company for compensation paid on premiums subsequently refunded.

Assignor hereby covenants and agrees that Assignor is the absolute and sole owner of said compensation, free from assignment or encumbrance of any kind or character whatsoever, and has full right and lawful authority to so assign same. The Assignor shall at all times defend, indemnify and hold harmless the Company and its officers, agents, and employees from and against any and all suits, actions, losses, damages, claims, expenses (including but not limited to the Company's legal expenses) and liability of any character, type or description arising out of the execution or performance of this assignment.

Assignor Signature ____________________________ Dated ________________________

Assignor Name ____
(Print)

Assignee Signature_____________________________ Dated ________________________

The Company acknowledges receipt of, and consents to the foregoing assignment, but assumes no responsibility for the validity or sufficiency hereof. This assignment is effective on the date signed by an authorized representative of the company.

By ____ Dated _______________________
(Authorized Company Signature)

Company Representative Name ___________________________________ Title _______________
(Print)

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Electronic Payment (ACH) Authorization Agreement

I hereby authorize ____________________to deposit any amounts owed me by initiating credit entries to the bank account listed below in the amounts specified. Also, I authorize ____________________the right to correct any Electronic Funds Transfer resulting from an erroneous overpayment by debiting my account for an amount not to exceed the original amount of the erroneous credit. This authorization is to remain in force until the company receives written notice from me of its termination in such time and in such manner as to afford the company a reasonable opportunity to act on it.

Vendor Information

Name (please print): ____

Social Security Number: ☐☐☐-☐☐-☐☐☐☐

OR

Tax ID Number: ☐☐-☐☐☐☐☐☐☐

Address: ____

____

Deposit Information

Check One: ☐ Checking ☐ Savings Requested Start Date for ACH:____________________________

Check One: ☐ New ☐ Change ☐ Stop

Bank Routing #☐☐☐☐☐☐☐☐☐ Bank Account # ☐☐☐☐☐☐☐☐☐☐☐☐

MUST ATTACH A COPY OF A VOIDED CHECK

Signature ____ Date ____________________________

FINANCE USE ONLY	
RECEIVED:	PS VENDOR #:
ENTERED INTO PEOPLESOFT:	

Form **W-9**
(Rev. September 2007)
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, if different from above

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership
☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=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 Line 1 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

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).

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.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,