

GENERAL AGENT *Contracting List*



Dear Agent/Agency,

To become contracted to sell **MedAmerica**, please return the following documents to Insurance Advisors Direct:

- Producer Profile
- Automatic Deposit
- License, Void check, E&O

Please send your contracting paperwork to:

Email: htalley@iadinsures.com

Fax: (248)946-4645 Attn: Licensing

Mail: Insurance Advisors Direct | 39555 Orchard Hill Place, Ste 203 | Novi, MI 48375

If you have any questions, please call IAD at (248)946-4640 x105 and ask for Heather Talley.

Thank you for your interest in **MedAmerica**, we look forward to working with you.



Insurance Advisors Direct

Agency, LLC

39555 ORCHARD HILL PLACE, SUITE 203, NOVI, MI 48375
800.381.0977 | WWW.INSURANCEADVISORSDIRECT.COM

PRODUCER PROFILE

You may not solicit applications on Our behalf until your appointment has been processed according to state insurance department regulations. Applications dated prior to this agreement and/or appointment effective date will be returned.

I. PRODUCER INFORMATION: (ALL FIELDS are <u>REQUIRED</u> unless otherwise indicated.)						
Producer Name (First, MI, Last)		Social Security Number		National Producer No.-NPN#		
Legal Residence Street Address (PO Box Not Adequate-Must Provide Street)			Mailing/Delivery Street Address (if different)			
City	State	Zip	City	State	Zip	
()	()	()	()	()	()	
Business Phone	Business Fax	Home Phone (Optional)	Mobile Phone (Optional)			
MM / DD / YYYY	<input type="checkbox"/> Male <input type="checkbox"/> Female					
Date of Birth	Sex	Email				
Your Agency Name (if applicable)			Agency Tax ID (if applicable)			
II. ERRORS AND OMISSIONS – Copy of E/O required that lists you as covered under the policy.						
Carrier Name		Policy Number		Expiration Date		
				MM / DD / YYYY		
III. PRODUCER'S STATEMENTS (Check Yes or No)					Yes	No
1. Have you ever been convicted or pled nolo contendere for any offense other than minor traffic violations?						
2. Have you ever filed for bankruptcy, been a party in an insolvency proceeding or been a party to a tax lien?						
3. Has your insurance license ever been fined, suspended, placed on probation, or is currently under investigation?						
4. Are you now, or have you ever been, in debt to any insurance agency or carrier?						
If your answer is "YES" to any of the above, please provide details on a separate sheet of paper and attach						
IV. FAIR CREDIT REPORTING ACT NOTICE:						
<p>You are hereby notified that a background investigation and license verification will be completed on You prior to Your appointment with Us. You authorize a release of written and verbal information about Yourself that may contain facts about Your background, general reputation and license to solicit insurance. You have the right to make a written request for information on the Reporting Agency as well as the nature and scope of the investigation. Furthermore, You have the right to (a) be told if the information in the investigative report negatively impacts Your application; (b) contact the Reporting Agency for full disclosure of the information contained in the investigative report; (c) dispute inaccurate information with the Reporting Agency. You can request a copy of the FCRA by contacting the Federal Trade Commission, Bureau of Consumer Protection - FCRA, Washington, DC 20580.</p>						
V. RESIDENT STATE APPOINTMENT REQUEST AND REQUIREMENTS----						
Check the <i>ONE</i> State you are Licensed as a RESIDENT AGENT						
<input type="checkbox"/> AL <input type="checkbox"/> AK <input type="checkbox"/> AZ <input type="checkbox"/> AR <input type="checkbox"/> CA <input type="checkbox"/> CO <input type="checkbox"/> CT <input type="checkbox"/> DE <input type="checkbox"/> DC <input type="checkbox"/> FL <input type="checkbox"/> GA <input type="checkbox"/> HI <input type="checkbox"/> ID <input type="checkbox"/> IL <input type="checkbox"/> IN <input type="checkbox"/> IA <input type="checkbox"/> KS <input type="checkbox"/> KY <input type="checkbox"/> LA <input type="checkbox"/> ME <input type="checkbox"/> MD <input type="checkbox"/> MA <input type="checkbox"/> MI <input type="checkbox"/> MN <input type="checkbox"/> MS <input type="checkbox"/> MO <input type="checkbox"/> MT <input type="checkbox"/> NE <input type="checkbox"/> NV <input type="checkbox"/> NH <input type="checkbox"/> NJ <input type="checkbox"/> NM <input type="checkbox"/> NY <input type="checkbox"/> NC <input type="checkbox"/> ND <input type="checkbox"/> OH <input type="checkbox"/> OK <input type="checkbox"/> OR <input type="checkbox"/> PA <input type="checkbox"/> RI <input type="checkbox"/> SC <input type="checkbox"/> SD <input type="checkbox"/> TN <input type="checkbox"/> TX <input type="checkbox"/> UT <input type="checkbox"/> VT <input type="checkbox"/> VA <input type="checkbox"/> WA <input type="checkbox"/> WV <input type="checkbox"/> WI <input type="checkbox"/> WY						
<input type="checkbox"/> Copy of Individual Resident License attached.			<input type="checkbox"/> Copy of Partnership Certification attached (if required by Resident State.)			
<input type="checkbox"/> Copy of LTC CE attached (if required by Resident State.)			<input type="checkbox"/> Massachusetts Only: Acknowledgement of Training signed and attached.			

VI. NON-RESIDENT STATE APPOINTMENT REQUEST AND REQUIREMENTS-
 Check All States You are Requesting a Non-Resident Appointment in.
 Nonresident Agents in AL/FL/GA/MA/MT/NM/PA/SC/VA/WI/WV must be licensed to receive overrides-Please include a copy of your license(s). In AL/FL/GA/MA/VA appointment is required to receive overrides.

<input type="checkbox"/> AL <input type="checkbox"/> AK <input type="checkbox"/> AZ <input type="checkbox"/> AR <input type="checkbox"/> CA <input type="checkbox"/> CO <input type="checkbox"/> CT <input type="checkbox"/> DE <input type="checkbox"/> DC <input type="checkbox"/> FL <input type="checkbox"/> GA <input type="checkbox"/> HI <input type="checkbox"/> ID <input type="checkbox"/> IL <input type="checkbox"/> IN <input type="checkbox"/> IA <input type="checkbox"/> KS <input type="checkbox"/> KY <input type="checkbox"/> LA <input type="checkbox"/> ME <input type="checkbox"/> MD <input type="checkbox"/> MA <input type="checkbox"/> MI <input type="checkbox"/> MN <input type="checkbox"/> MS <input type="checkbox"/> MO <input type="checkbox"/> MT <input type="checkbox"/> NE <input type="checkbox"/> NV <input type="checkbox"/> NH <input type="checkbox"/> NJ <input type="checkbox"/> NM <input type="checkbox"/> NY <input type="checkbox"/> NC <input type="checkbox"/> ND <input type="checkbox"/> OH <input type="checkbox"/> OK <input type="checkbox"/> OR <input type="checkbox"/> PA <input type="checkbox"/> RI <input type="checkbox"/> SC <input type="checkbox"/> SD <input type="checkbox"/> TN <input type="checkbox"/> TX <input type="checkbox"/> UT <input type="checkbox"/> VT <input type="checkbox"/> VA <input type="checkbox"/> WA <input type="checkbox"/> WV <input type="checkbox"/> WI <input type="checkbox"/> WY	
<input type="checkbox"/> Copy of Agent NON-Resident License(s) attached.	<input type="checkbox"/> Copy of Partnership Certification attached (if required by State OR By Products Selling)
<input type="checkbox"/> Copy of LTC CE attached (if required by State.)	<input type="checkbox"/> Massachusetts Only: Acknowledgement of Training signed and attached.
<input type="checkbox"/> Check made payable to "MedAmerica Insurance Company" for ALL applicable <u>nonresident appointment fees</u> . Please contact your Sponsoring General Agent for a current fee listing.***Fees are not required as long as an application for the state is submitted with request.	

VII. New Business

Have you solicited an application on MedAmerica's Behalf?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes to the above question: Please provide the date the application was signed by the applicant and what state.	_____ / _____ / _____ MM / DD / YYYY	
	Application Sign Date	State of Solicitation

VIII. Producer Signature and Corporate Code of Business Conduct Acknowledgement

I certify that all of the information provided above is true and accurate.
 I acknowledge that I have received The Lifetime Companies (the "Corporation") Code of Business Conduct. I have read the Code and understand its purpose. I understand that the Code applies to me and I agree to abide by all of its provisions. I understand that I have a duty to report any violations of the Code and that if I fail to report a violation of any provision of the Code that I may face termination of my contract to represent the Corporation.

X

Producer Signature	Date
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IX. SPONSORING GENERAL AGENT

Sponsoring Agency Name:		Print Name of Person Signing for Sponsoring Agency	
By the Signature below, I attest by the authority of the above agency, that the named agency is sponsoring this person as a producer to be appointed with Medamerica and recognize it is our agency's responsibility to train this producer.			
This producer is: (Check One)			
<input type="checkbox"/> Commissioned Producer and the Commissioned Producer agreement and commission schedule are attached.			
<input type="checkbox"/> Licensed Only Producer and the signed Licensed only agreement is attached.			
Mail is to be delivered to: Check One (Excludes 1099-Misc-These are mailed to Producer Home Address or Agency Business Address)			
<input type="checkbox"/> Commissioned Producer Business Address			
<input type="checkbox"/> Sponsoring General Agent			
<input type="checkbox"/> Supervising General Agent			
X			
Signature of Sponsoring Agency Principal (owner/president/person with authority to sign)		Title of person Signing	Date



An Excellus Company

MedAmerica Insurance Company
Home Office: Pittsburgh, PA

MedAmerica Insurance Company of New York
Home Office: Rochester, NY

Automatic Deposit of Commission Payments

Please return form to: **LTC OPERATIONS**
165 Court St.
Rochester, NY 14647
Telephone: 800-724-1582
Fax # (585) 238-3693

Use this form for MedAmerica Insurance Company(116) and Principal Financial Group(119)

Account Holder Name: _____
(Please Print)

Contact Name (If Company Name and not Individual): _____
(Please Print)

Address: _____
(Please Print) Street City State Zipcode

Phone Number: (____) _____

Bank Name: _____ **Bank Account #:** _____

ABA Number (always 9 digits):

Account Type **Checking (Attach a Voided Check)** **Savings** **Credit Union**

Note: With Savings accounts and Credit Unions be sure you have checked with your financial institution and recorded the correct ABA number and Account Number.

I authorize MedAmerica Insurance Company to automatically deposit commission payments due to the Account Holder named into the bank account specified above. This authorization shall remain in force until I give notification of termination to MedAmerica Insurance Company or my financial institution in writing.

X _____ X _____
Signature of Account Holder Date Signature of Joint Account Holder Date