GENERAL AGENT
Contracting List

Dear Agent/Agency,

To become contracted to sell Priority Health, please return the following documents to Insurance Advisors Direct:

- Agent Agreement
- Application for Contract
- Attachment B
- License, E&O, Void check
- W-9, for general agents

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 for Heather Talley

Thank you for your interest in Priority Health, we look forward to working with you.

Insurance Advisors Direct
Agency, LLC

PriorityHealth

Priority Health Individual Market
AGENT AGREEMENT

This Agreement is made as of the __ day of ____________ , 20__ (the "effective date") between PRIORITY HEALTH, a Michigan nonprofit corporation and health maintenance organization ("Priority Health") and PRIORITY HEALTH INSURANCE COMPANY, a Michigan insurance company ("PHIC") (collectively the "Companies")
and ____ with a principal place of business at ____ ("Agent").

RECITALS:

1. Priority Health has a certificate of authority to operate a health maintenance organization, offering Medicare Supplement (Medigap) plans and Medicare Advantage plans (the "Medicare Plans"). Priority Health has been designated by the Center for Medicare and Medicaid Services ("CMS") as a sponsor of Medicare Advantage plans.

2. PHIC has a certificate of authority to operate an insurance company, offering individual insurance plans such as the My**Priority**SM Plans (the "Individual Plans") and Medicare Prescription Drug Plans (included with "Medicare Plans"). The Medicare Plans and the Individual Plans are referred to collectively as the "Plans." PHIC has been designated by CMS as a Prescription Drug Plan.

3. Agent is licensed in Michigan to market or sell individual health benefit plans. Agent must also be certified by Priority Health to sell the Medicare Plans.

4. Agent is designated as Agent by a member of the general public ("Individual") purchasing a Plan.

5. The Companies and Agent desire to enter into an agreement according to which Agent shall market the Plans and the Companies shall compensate Agent for Agent's services.

6. Agent is a "business associate" of the Companies as such term is defined by federal regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 (as amended, "HIPAA").

ACCORDINGLY, the parties agree as follows:

1. Services to the Companies.

1.1. The Companies authorize Agent to represent, and Agent agrees to represent, the Companies in the marketing of the Individual Plans to Individuals. In representing the Companies in the marketing of the Individual Plans, Agent shall

1.1.1. Only utilize sales material, including advertising materials, authorized by the Companies,

1.1.2. Adhere to all policies, rules and regulations provided by the Companies or their representatives to Agent in writing with regard to sales or marketing (including, without limitation, Attachment A to this Agreement) and applicable federal and state laws, and

15.3. If to Agent:

Any notices required under this Agreement shall be sent to the address given by Agent on the signature page below unless a written change of address notification is received from Agent.

16. Assignment.

16.1. Neither party may assign this Agreement except with the prior written consent of the other party. Unless otherwise agreed, any such assignor shall remain liable for all assigned obligations in the event of any failure of performance by the assignee. All of the terms, provisions and obligations of this Agreement shall be binding upon and shall inure to the benefit of the parties to this Agreement and their respective heirs, representatives, successors and assigns.

17. Relationship of Parties.

17.1. None of the provisions of this Agreement are intended to create, nor shall be deemed or construed to create, any relationship between the Companies and Agent other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement. Except as this Agreement provides otherwise, none of the parties, nor any of their respective employees or agents, shall be construed to be the agent, partner, co-venturer, employee, or representative of the other.

18. Counterparts.

18.1. This Agreement may be executed simultaneously in two or more counterparts, each of which shall be deemed an original, but all of which shall constitute one and the same instrument.

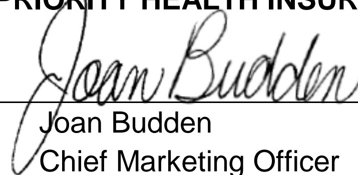
IN WITNESS WHEREOF, the parties have executed this Agreement as of the day and year first written above.

AGENT

Signature

Dated: ____________________

PRIORITY HEALTH
PRIORITY HEALTH INSURANCE COMPANY



Joan Budden
Chief Marketing Officer

PriorityHealth

Application for Contract

Profile Information

Name: ______________________________ SS #: ____ - ____ - ____

(First) (Middle Initial) (Last)

Business address (the address of the physical location from which you ordinarily conduct business, whether it is your organization's home office, a satellite office, or from your own home):

____

(Street) (City) (State) (Zip)

Corporate or FMO/GA address:

____

(Street) (City) (State) (Zip)

Email Address: ______________________ Fax : ( ) ______________

Business Phone: ( ) ______________ Cell Phone: ( ) ______________

Are you now, or have you ever been, appointed with Priority Health or any of its subsidiaries? ☐ Yes ☐ No

If yes, list lines of business: ______________________________

Licensing Information

Accident and Health License Number: ______________ Expiration Date: ______________

List states in which you are currently licensed: ______________________________

Errors & Omissions (E & O) Coverage Information

E & O Policy Carrier: ______________________ E & O Policy Number: ______________

Effective date: __________ Expiration date: __________ Policy Amount: __________

General Information

Please respond to all questions for you personally and any organization over which you have exercised control. If you answer "YES" to any of these questions, provide complete details on a separate sheet of paper.

1. Within the past 10 years, has any E & O carrier denied, paid claims on, or canceled your coverage? ☐ Yes ☐ No

2. Are you involved in any pending or current litigation, investigations or E & O claims? ☐ Yes ☐ No

3. With the exception to routine traffic violations, have you EVER been convicted of, or plead guilty or nolo contendere (no contest) in a court to:

   (a) a misdemeanor, or ☐ Yes ☐ No

   (b) a felony ☐ Yes ☐ No

   (Such convictions will not automatically disqualify Agent candidates. The seriousness and nature of the crime, date of conviction and rehabilitation will be considered)

4. Have you ever been discharged or permitted to resign from your employment because you were accused of: ☐ Yes ☐ No
   - (a) violating investment-related or insurance-related statutes, regulations, rules, or industry standards of conduct? ☐ Yes ☐ No
   - (b) fraud or the wrongful taking of property? ☐ Yes ☐ No
   - (c) violating company rules? ☐ Yes ☐ No

5. Have you ever been fined, reprimanded, sanctioned or been the subject of a consent decree in any state for a violation of insurance laws, HMO regulations or other administrative regulations? ☐ Yes ☐ No

6. Do you have any outstanding or unpaid indebtedness to an insurance company or General Agent? ☐ Yes ☐ No

7. Have you **EVER** had your insurance license suspended, revoked or terminated? ☐ Yes ☐ No

8. Have you **EVER** had a securities license or registration suspended, revoked or terminated? ☐ Yes ☐ No

9. Within the past 10 years, have you ever had a complaint filed against you that resulted in a fine, penalty, cease or desist order, censure or consent order? ☐ Yes ☐ No

10. Are there any outstanding or pending judgments, liens, or tax liens against you? ☐ Yes ☐ No

11. Have you ever defaulted on (a) a promissory note, or (b) any other debt, including consumer or credit card debt? ☐ Yes ☐ No

12. Within the past 5 years, have you initiated bankruptcy proceedings or been declared bankrupt? ☐ Yes ☐ No
    (If yes, attach a copy of court papers.)

13. Professional designations: ☐ CLU ☐ CHFC ☐ LUTC ☐ RHU ☐ CPCU ☐ Other: ____________

I hereby certify that my answers to the questions contained in this application are true and correct. I acknowledge that PRIORITY HEALTH, a Michigan health maintenance organization ("Priority Health") and PRIORITY HEALTH INSURANCE COMPANY, a Michigan insurance company ("PHIC") (collectively the "Companies") have informed me that investigative reports may be conducted on Agents for licensing purposes, initial and renewal state appointments, and at any time the Companies, at their discretion, deem it necessary to conduct background investigations. I expressly authorize the Companies to conduct these investigations and authorize all persons and entities (including past and present employers) to provide the Companies all requested information. I release from liability all persons and entities which supply said information to the Companies and agree to hold the Companies harmless from any liability for conducting this investigation and/or using said information. I authorize the Companies to use these investigative reports and to provide these reports and any other pertinent information to all third parties where the third parties' legal interests and/or obligations are involved. I also authorize the Companies to distribute any financial, business, legal, tax or work performance history regarding me that it receives from third parties or which is generated by the Companies' data source that is not part of the investigative report. I acknowledge that this application will form a part of my Agent Agreement with the Companies. I further understand that if any information provided in this application is found to be incorrect or incomplete, it may be grounds for rejecting this application or for termination of my contract, all in the sole discretion of the Companies.
My signature below also signifies my agreement to the Companies' current production requirements for the Individual Plans that can be viewed at www.priorityhealth.com.

PriorityHealth

I have completed all necessary documents. I understand the Companies will accept business from me upon completion and acceptance of the Agent Application, Agreement, Assignment of Commission and Agent Commission Schedule and Production Requirements for the My**Priority**SM **Individual plans, Priority Health Medigap Plans, and Priority Health Medicare Plans.**

_______________________________________ _______________________________________

Signature of Applicant Date

PriorityHealth

ATTACHMENT B

Assignment of Commissions

Commission Assignment

Please Select Desired Payment Option Below and provide requested information. Multiple options may be selected.

Note: Two separate agent numbers will be provided if multiple payments options are selected; it is the agent's responsibility to submit applications with their correct agent number.

Product	Pay to Agent		Pay to Agency		Field Market Organization (FMO) / General Agency (GA) (if applicable)
MAPD	Name:		Agency:		FMO / GA Name: INSURANCE ADVISORS DIRECT B04479
	SS#:	– –	FIN:	–	
Medigap	Name:		Agency:		FMO / GA Name: INSURANCE ADVISORS DIRECT B04479
	SS#:	– –	FIN:	–	
My**Priority**	Name:		Agency:		FMO / GA Name: INSURANCE ADVISORS DIRECT B04479
	SS#:	– –	FIN:	–	

In the Event of termination with your Agency: For These Products:

1. Collateral Assignment: all owed commissions will be paid to Agent. ☐ Medicare ☐ Medigap ☐ My**Priority**
2. Absolute Assignment: all owed commissions will be paid to Agency ☐ Medigap ☐ My**Priority**
   (not applicable to Medicare Advantage and/or MAPD commissions).

Effective date if other than effective date of Agreement: ______________________________

NOTE: Approval and appointment to sell Priority Health Medicare Plans is incomplete until all certification requirements for Medicare Advantage (MAPD) sales are completed.

Agent Acknowledgement

I hereby bind my Beneficiary and Personal Representative to the full performance of the terms and conditions of this Assignment of Commissions. PRIORITY HEALTH and PRIORITY HEALTH INSURANCE COMPANY are hereby directed and authorized to make payment of all above specified sums due here as directed above.

This Assignment of Commissions shall remain in effect until written notice of the termination hereof by me has been received by PRIORITY HEALTH and PRIORITY HEALTH INSURANCE COMPANY.

Agent Signature: ______________________________ Date: ____________________

Agent Printed Name: ______________________________

EXHIBIT (PAGE 1)

Form **W-9** (Rev. November 2005) 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 ☐ Other ▶ ---------------- ☐ Exempt from backup withholding

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. person (including a U.S. resident alien).

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 ▶**

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.

U.S. person. 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.

In 3 above, 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.

For federal tax purposes, you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

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,

Cat. No. 10231X Form **W-9** (Rev. 11-2005)

PriorityHealth

Direct Deposit/Electronic Funds Transfer Agreement

This Direct Deposit/Electronic Funds Transfer Agreement (the "Agreement") is made as of __________________________________, 20____ by and between ________________________ _________________________________, an individual or agency, ("Agent") with offices at: ____ and **Priority Health,** a Michigan non-profit corporation, **Priority Health Insurance Company,** a Michigan Insurance Company, and **Priority Health Managed Benefits¸ Inc.,** a Michigan corporation, (collectively, "Priority Health"), with offices at 1231 East Beltline NE, Grand Rapids, MI 49525.

Purpose:

This form authorizes Priority Health to deposit payments owed to Agent by direct deposit into the account indicated on the Agent Commission Direct Deposit Payment Information Form. This authorization will remain in effect until termination. Either party may terminate this agreement upon thirty (30) days notice to the other.

The parties agree that:

Information:

- Priority Health may reasonably rely upon the account information given by the Agent.
- It is the responsibility of the Agent to provide accurate information and changes to that information as necessary.
- Any change shall be effective no less than fourteen (14) days after notice of such change is received.
- Agent agrees to hold Priority Health and its agents harmless from any and all claims arising from Priority Health's or its agent's reliance on information that Agent supplied to them.

Security and Privacy:

- Either party may suspend operations upon reasonable and timely notice to the party in the event that a party's performance is delayed or prevented by an act of God, natural disaster, computer or communication failure or other cause beyond the affected party's reasonable control.
- Suspension of operations under this Agreement shall not relieve either party of its obligation to the other party under the Agent Contract.
- Agent shall be assigned a PIN number to authenticate the identity of the Agent.

Liability:

- Each party shall be liable to the other for the acts or omissions of its respective employees, subcontractors, financial institutions, and/or other agents in connection with this Agreement.
- Each party shall bear the respective fees and other charges assessed by its designated financial institutions.

- Neither party shall be liable for the acts of omissions of any third party not under its control.
- Neither party shall be liable to the other for any special, incidental, exemplary or consequential damages arising from or as a result of any delay, omission or error in the electronic transmission or receipt of any data.

This Agreement shall be interpreted by the laws of the state of Michigan.

All notices required or permitted to be given with respect to this Agreement shall be given by mailing the same postage prepaid, or given by fax, email or courier to the addresses below.

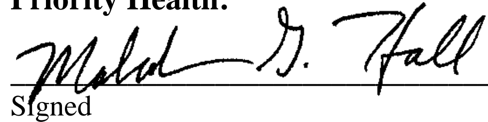
If to Priority Health:

Agent Services
1231 East Beltline NE
Grand Rapids, MI 49525
800 471-2504 (option 3)
Fax: (616) 464-7495
Email: ph-agent.center@priorityhealth.com

If to Agent:

____
____
____
Fax: __________________________
Email: ________________________

Priority Health:



Signed

Malcolm G. Hall
Printed

Agent:

____
Signed

____
Printed

____
Date

PriorityHealth

Exhibit A

Agent Commission Direct Deposit Payment Information Form

Notes

1. Please fill out all information and return this form with your Agent Agreement or return it via:

   Mail Priority Health-EFT Payment
   Agent Services
   1231 East Beltline, NE
   Grand Rapids, MI 49525-4501

   Fax 616 464-7495

   Email ph-agent.center@priorityhealth.com

2. **Important:** Please include either a voided check, copy of a voided check, or bank letter with this form.

Agent/Agency name: ____

Agent/Agency Tax ID number: __________________________________

Financial institution information

Name: ____

❑ Checking ❑ Savings

Account number (include leading zeros): _________________________

ABA/routing number (9 digits at bottom of check): __________________

Please provide user name (s) for those authorized to receive deposit notifications.

Primary contact: ____

Email: ____________________________________

Agent Center user name: ____________________________

Phone: ( ) _____________________

Secondary contact: _____________________________________

Email: ____________________________________

Agent Center user name: ____________________________

Phone: ( ) _____________________