Medicare Health Benefits
2716 S. 6th Avenue
Tucson, Arizona 85713
(520)760-6223
Fax (520) 760-6224

Contract

Please COMPLETE the following:

1. Signature on contracting forms
2. W-9
3. Direct Deposit form

Please SEND the following:

1. Certificate of Completion from the BCBS Pinpoint Global

If you have any questions please contact me at: (520) 396-3372 or via email:

yvonne@medicarehealthbenefits.com

BROKER INFORMATION SHEET
Medicare Health Benefits
2716 S. 6th Ave.
Tucson, AZ 85715

PLEASE PRINT

Name:_____

Address: _____

City: _____ State: _____ Zip Code:_____

Business Phone: _____

Cell Phone: _____

Email: _____

Social Security Number: _____ (Must have SSN for background check)

Tax ID: _____ (If different than SS#)

Date of Birth: _____

State Insurance License Number: _____

National Producer Number (NPN): _____

Affiliated Agency Name:_____

AHIP (date of completion) _____

Fax this Sheet to: 1-520-760-6224

OR scan and email to: yvonne@medicarehealthbenefits.com

ATTACHMENT A

INDIVIDUAL AGENT ADDENDUM

1. Acknowledgement. I, _____ ("Agent"), acknowledge that I have read the General Agent Agreement including the attachments thereto, and including the CMS Requirements Addendum (the "Agreement") between Blue Cross® Blue Shield® of Arizona ("Company") and Medicare Health Benefits ("General Agent"), and agree to be bound by and to comply with its terms.

2. **Certification**. I certify that I am properly licensed in Arizona in order to provide services and receive commissions under this Agreement, and attach a copy of my current license as proof. I agree to immediately provide General Agent with a copy of any renewal licenses issued to me, and to comply with all continuing education requirements and other requirements to maintain individual agent licensure.

3. **Notification**. I understand and agree that I will inform General Agent immediately if (i) my license expires or is suspended, terminated, or otherwise revoked in any state or jurisdiction in which services are performed; or (ii) I am disciplined or reprimanded by any state or federal regulatory entity.

4. **Termination**. If I fail to maintain a valid license or my license is restricted in any manner, or my appointment terminates for any reason whatsoever, this Addendum and the authorization by Company and General Agent to sell the plans listed in the Agreement shall automatically terminate.

5. **Termination for Cause**. This Agreement may be terminated by Company or General Agent for cause immediately upon the occurrence of the event giving rise to the termination including, without limitation, the following:

(a) Agent's license expires or is suspended, terminated, or otherwise revoked in any state or jurisdiction in which services are performed;

(b) Agent is disciplined or reprimanded by any state or federal regulatory authority in any way in connection with performance of his/her duties as an agent;

(c) Agent performs services for General Agent under this Agreement after having been disciplined or reprimanded by any state or federal regulatory authority in any way in connection with performance of his/her duties.

(d) Agent is convicted of a felony;

(e) Agent fails to provide proof of licensure within thirty (30) days of Company's written request; or

(f) Agent is in material breach of this Agreement. A material breach includes, without limitation, the failure by Agent to comply with Applicable Law. As used in this Agreement, Applicable Law means applicable state law and regulations, federal law and regulations, and CMS program guidelines and instructions applicable to the Medicare Advantage and Medicare prescription drug programs.

6. **Payment**. I agree to look solely to General Agent for payment for my services performed pursuant to this Addendum, and to hold Company harmless against any claims I may have against General Agent. For each member enrolled by Agent during the term of the Agreement from leads generated by Company or by Agent (a "Member"):

- Agent will be paid during 2013 an "Initial Rate" of four hundred thirteen dollars ($413.00) within thirty (30) days of the effective date of the Member's enrollment, only for those Members confirmed as initially eligible for Medicare or for those Members qualified by CMS as eligible for payment at the "Initial Rate."

- In addition, Agent will receive payments of the "Renewal Rate" of two hundred seven ($207.00) dollars, commencing in 2014, for each of an initial Member's five (5) subsequent calendar years of continuous enrollment, so long as Agent continues to be contracted with Company and remains in good standing with Company's regulatory and licensure requirements. Renewal commissions will be paid at a monthly proration of the annualized "Renewal Rate."

- For each newly enrolled Member who is not confirmed as initially eligible for Medicare and not qualified by CMS as eligible for payment at the "Initial Rate," Agent will be paid during 2013 and in subsequent years at the "Renewal Rate" of two hundred seven ($207.00) dollars for each of the second, third, fourth, fifth and sixth year in which such new Member has been continuously enrolled in Medicare, so long as Agent continues to be contracted with Company and remains in good standing with Company's regulatory and licensure requirements. Agent will be paid the "Renewal Rate" within thirty (30) days of the effective date of the Member's enrollment for enrollments effective in 2013.

Agent shall not be eligible for compensation if any of the following events occur: (i) The potential Member's application is rejected by CMS; (ii) Company reasonably determines that the potential Member's application is incomplete; (iii) the potential Member cancels the enrollment prior to official notification by CMS; (iv) the Member disenrolls from Company; or (v) General Agent's contract with Company terminates for any reason, unless agent is contracted directly with Company. Compensation previously paid to Agent for any disenrollees will be debited in full on the next invoice payment.

All undisputed amounts reflected on an invoice are due within thirty (30) days after the date of Company's receipt of an invoice from General Agent. Notwithstanding the foregoing, Company will not remit any payment to General Agent prior to the return to Company of this fully executed original Agreement, including Agent's Taxpayer ID number or Social Security number, as the case may be.

Signed: _____

Date: _____

Individual Agent Name: _____

License No.: _____

Taxpayer ID No.: _____

Social Security No.: _____

Date of Birth: _____

Home Address:

_____

Business Address:

_____

Business Phone Number: _____

Email Address: _____

2716 S. 6th Avenue
Tucson, Arizona 85713

(844) 245-4152
fax (520) 760-6224

RELEASE AND DEBIT BALANCE POLICY

The Consulting Agent/Agency shall be released from this agreement upon written request from Consulting Agent/Agency. Be it known that our release may not guarantee Agent/Agency release from our upline. Medicare Health Benefits/MHB Insurance Services LLC, herby agrees to provide a release letter for the Consulting Agent/Agency and down line agents.

This release is contingent on the Consulting Agent/Agency and it's down line agents:

- Not having a debit balance with Medicare Health Benefits/MHB Ins. Services, or our contracted Carriers or any chargebacks which will be paid from the Agency's override until there is $0 chargeback balance;
- After a period of six (6) months of no production with the Carrier's Plans; or if the parties agree at the time of release that the release is a mutual agreement;
- Mutual agreement to be released within three to five (3-5) business days.

Under no circumstances shall the release request be honored 30 days prior to Annual Election Period (AEP), during AEP; and/or within 90 days after January 1st effective date.

All requests for release shall disclose the reason(s) the release is being requested and be sent by the Agent/Agency to MHB via email or hardcopy to the address listed below:

Medicare Health Benefits, Inc.
2716 S. 6th Ave
Tucson, AZ 85713
anna@medicarehealthbenefits.com or yvonne@medicarehealthbenefits.com

This agreement is entered into between the two parties signing below, and remaining in effect until terminated.

MHB INSURANCE SERVICES, LLC.
GENERAL AGENCY

_____
Print Name or Company Name

_____ _____
Anna Rothhaar, COO Date

_____ _____
Company Representative Date

Form **W-9**
(Rev. October 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,

Medicare Health Benefits Inc.

MHB Direct Deposit Agreement Form

Authorization Agreement

I hereby authorize **Medicare Health Benefits Inc.** to initiate automatic deposits to my account at the financial institution named below.

Further, I agree not to hold **Medicare Health Benefits Inc.** responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until **Medicare Health Benefits Inc.** receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to the Payroll Department.

Account Information

Name of Financial Institution: _____

Routing Number: _____

Account Number: _____ Checking ☐ Savings ☐

Signature

Authorized Signature (Primary): _____ **Date:** _____

Authorized Signature (Joint): _____ **Date:** _____

Please attach a voided check or deposit slip and return this form to the Payroll Department.