



HEALTH INSURANCE INNOVATIONS LICENSING CHECK LIST

Please complete the required forms listed below to sell the HII Plans.

1. Complete and sign the HII Agent Information and Statement of Understanding Form
2. Sign the Commission Addendum (Include the name of your GA or MGA, if any)
3. Complete and sign the Fairmont Specialty Group Agent Profile Form
(To sell the Health Essential Plan)
4. Complete and sign the Commission Direct Deposit Agreement, and include a copy of a voided check
5. Complete and sign the IRS W-9 Form
6. Attach a copy of your Errors & Omissions Insurance
7. Include current copies of your insurance agent license(s) for each state you plan to sell the HII plans. *(Resident and Non-Resident and include any agency licenses)*

Submitted By: _____ Date: _____
(Please Print)

Recruited By: _____

Please call 1-877-376-5831 if you have any questions about the licensing process.

Mail or fax your completed forms and attachments to your GA / MGA or you can send them to Health Insurance Innovations via fax, email or mail.

Toll Free Fax: 1-877-376-5832
Email: lkundivich@hii-corp.com
Mail: Health Insurance Innovations, LLC
218 E Bearss Ave., Suite 325 • Tampa, FL 33613



HEALTH INSURANCE INNOVATIONS (HII) AGENT INFORMATION FORM

COMPLETE THE FOLLOWING INFORMATION ABOUT YOURSELF:

Agent Name _____ Date of Birth _____ Social Security# _____

Corporation/Agency Name _____ Tax I.D.* _____ Email _____

Business Street Address _____ City _____ St. _____ Zip _____

Resident Street Address _____ City _____ St. _____ Zip _____

Business Telephone # (_____) _____ Fax # (_____) _____ Resident Telephone # (_____) _____

** If we are to pay Marketing Fees/ Commissions to an Agency or Corporation, and you are not the Owner / Officer, we need the assignment below signed by you and we must have another License Request Form completed by the Agency Owner / Officer; and copies of their license. Include the Agency's license if applicable in your state.*

ANSWER THE FOLLOWING QUESTIONS:

1. Have you ever been convicted of a felony? YES NO
2. Have you ever been involved in an investigation with any State Insurance Department? YES NO
3. Has your license ever been suspended, cancelled or revoked by any State Insurance Department? YES NO
4. Have you ever filed Bankruptcy, been sued or had a judgment entered against you? YES NO

Any "YES" answer above requires a separate statement, including dates, location, basis of charge and legal documentation indicating disposition of case.

1. Do you carry errors and omissions coverage? YES NO (If YES, list carrier name and limits) _____
 2. What lines of insurance are you licensed to sell for: Life Accident / Health Other _____
 3. Please list the states where you hold a license: State _____ License # _____; State _____ License # _____; State _____ License # _____;
- Attach copies of your resident and all nonresident licenses. **(We do not need an appointment fee.)**

ASSIGNMENT OF MARKETING FEES / COMMISSIONS REQUEST:

Only complete the following if you want HII to pay your Marketing Fees/ Commissions to a Corp., Agency or another Agent.

I _____ Code #: _____ hereby assign to
 Assignee: _____ all of my
 right, title, and interest in Marketing Fees and/or renewals to which I am now entitled or become entitled, under existing contracts and agreements, heretofore entered into by and between myself and HII I hereby authorize and empower HII, to pay assignee all Marketing Fees and renewals now due or which may accrue under said contracts, for a period of one year from this date and thereafter until such time as I terminate this assignment by written notice to HII. I agree that such payments of Marketing Fees under my contract are the same as if payment was made directly to me. I hereby covenant and agree that I am the absolute and sole owner of said Marketing Fees, free from prior assignment or any encumbrance of any kind or character whatsoever, and that I have full right and lawful authority to sell and transfer the same as aforesaid.
 Witness my hand this _____ day of _____, Year _____, Agent's Signature _____
 CAUTION: The person assigning his or her Marketing Fees (assignor) will not recover the right to receive any further Marketing Fees during the one year period from the date of this assignment unless and until the person to whom such rights are assigned (assignee) releases, in writing, his or her rights to receive such Marketing Fees. Please be certain you understand this before signing the form. This instrument may be revoked, in writing, by the Assignor at any time after the one year period.
 Address of Assignee: _____ Tax I.D.#: _____

STATEMENT OF UNDERSTANDING FORM:

This Statement of Understanding must be signed to be in effect, and is between undersigned Agent and Health Insurance Innovations, herein referred to HII. HII agrees to pay Marketing Fees / Commissions on the plans listed on the attached Addendum accordance with and subject to the conditions and covenants below.

- The term "monthly plan cost and paid" shall mean monies, excluding any enrollment fee, monthly administrative fee or association dues, due and paid for the plan after the effective date of this Agreement by each member and for whom the Agent is the representative of record.
- Marketing Fees / Commissions shall be payable only when Agent is (a) properly approved to transact business for HII and (b) is continuously recognized by HII as the Agent of record to receive said Marketing Fees / Commissions.
- This Agreement may be terminated by either party with a 30 days written notice but only with respect to new cases. Such terminations will have no effect on the payment of Marketing Fees / Commissions on business written prior to the effective date of termination as may otherwise be payable.
- No advertising material (on paper, over the radio or television or on the Internet) bearing HII or our product name or describing any named product distributed by HII can be produced without prior written approval from HII.
- The Agent is an independent contractor, not an employee of HII
- The Agent has no authority to act on behalf of HII, bind coverage, waive or alter any provision of the application or the Product under which membership is issued.
- Representations and opinions of the Agent are not binding on HII plans.
- By signing below I am giving HII prior written express invitation and permission to transmit facsimile and email advertisements to me.

READ CAREFULLY BEFORE SIGNING:

The above information is true and complete. I understand false statements on this form may be sufficient cause for termination. I have read the Statement of Understanding and understand that if these guidelines are not followed, the result will be termination of this Agreement.

Agent Signature: _____ Date: _____ Title: _____

GA Name: **Dodd Brokerage** HII Code #: **E100606000** MGA Name: _____ HII Code #: _____

Recruited By: _____

**Mail your completed required forms and a copy of your current license(s) to your GA or MGA.
 If none is listed, fax completed them toll free to: 1-877-376-5832
 You can mail the forms to HII, 218 East Bearss Ave., Suite 325, Tampa, FL 33613**



**Health Insurance Innovations
Producer Commission Addendum**

Health Essential:	First Year 20%	Renewal Years 5%
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The Agent commission listed above is payable based on issued collected premiums, minus administration fees, enrollment fee, association dues or refunds; and for applications received and issued after the effective date of this Agent Commission Addendum.

Agent Signature: _____ Title: _____ Date: _____

Health Insurance Innovations

By: _____ Title: _____ Date: _____

Complete the following information:

Print Name: _____

E-Mail: _____ Company Name: _____

Address: _____ City: _____ St: _____ Zip: _____

GA Name: **Dodd Brokerage** Agent Code: **E100606000** Email: _____

SGA Name: _____ Agent Code: _____ Email: _____

MGA Name: _____ Agent Code: _____ Email: _____

**Health Insurance Innovations, LLC
218 E Bearss Ave., Suite 325 • Tampa, FL 33613
Phone: (877) 376-5831 • Fax: (877) 376-5832**

Agent Profile Form

<i>Last Name</i>			<i>First Name</i>			<i>Middle</i>									
<i>Social Security Number</i>						<i>Date of Birth</i>									
<i>Agency Name</i>						<i>Tax ID#</i>									
<i>Resident Address</i>						<i>City</i>		<i>State</i>	<i>Zip</i>						
<i>Business Address</i>						<i>City</i>		<i>State</i>	<i>Zip</i>						
<i>Business Phone</i>				<i>Cell Phone</i>			<i>Fax Number</i>								
<i>Email</i>						<i>Website</i>									
<i>Preferred Mailing Address</i>				<input type="checkbox"/>	<i>Business</i>			<input type="checkbox"/>	<i>Resident</i>						
<p>Please check off the states below, in which you will be representing Fairmont Specialty. Please provide a copy of insurance license(s) for each state checked.</p> <p>If assigning commissions to an agency or corporation, please also provide a copy of the agency license (if applicable).</p>															
<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										
<p>Notice Regarding Background Checks</p> <p>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)</p> <p>We will notify you if your background report results are unfavorable and we consequently decline your license appointment. In addition, you will be advised to discontinue submission of business to our company and/or service to any of our clients as well. In the event that the information reflected in the criminal report is incorrect, we will advise you of the protocol to appeal.</p>															

For Office Use Only – To be completed by FS Underwriter authorizing the above appointment request.										
<i>Underwriter's Name</i>						<i>Underwriter's Signature</i>				
<i>Fairmont Specialty Relationship</i>			<input type="checkbox"/>	<i>Master Agent</i>		<input type="checkbox"/>	<i>Sub-agent</i>		<input type="checkbox"/>	<i>Other (please explain below)</i>
<i>Appointment requested for</i>		<input type="checkbox"/>	<i>Accident and Health</i>				<input type="checkbox"/>	<i>Property and Casualty</i>		
<i>Appointing Company</i>			<input type="checkbox"/>	<i>US Fire Insurance Company</i>			<input type="checkbox"/>	<i>The North River Insurance Company</i>		
<i>Underwriter's Comments</i>										

Fax or Mail to: Health Insurance Innovations Fax: 877.376.5832
Mailing Address: 218 E. Bearss Ave., Suit 325, Tampa, Florida 33613

AUTHORIZATION FOR A DIRECT DEPOSIT TRANSACTION

Please be sure you complete all 4 steps

Administrative Concepts, Inc.

Merchant ID# _____

Step 1: Customer Information

Company Name _____

Contact Full Name _____
Last First Middle

Company Address _____
Address City State Zip

Work Phone ()-- --

Step 2: Bank Account Information

Bank Name _____

Address _____

Routing Number _____
(Must be 9 Digits)

Account Number _____ X

Type of Account Checking Savings

Note: Attach a voided check from your checking or savings account over the word "VOIDED CHECK" .

Step 3: Authorization Signature (s)

Signature of Authorizer _____ Date / /

Printed Name of Authorizer _____

Step 4: Mail / Faxing Authorization Agreement

Mailing Address
218 E. Bearss Ave
Suite 325
Tampa, Florida 33613

Fax Number
877-376-5832

Authorized Agent
Health Insurance Innovations

I am signing up for a direct deposit plan. I agree Administrative Concepts, Inc. or its authorized agent may transfer funds to the above referenced account on a monthly basis. I can cancel this automatic deposit at any time by calling or writing to Administrative Concepts, Inc. or its authorized agent. I agree that Administrative Concepts, Inc. or my financial institution can cancel automatic payment for my account for any reason, at any time, with or without prior notice to me. I acknowledge that the origination of these deposits to my account must comply with U.S. laws. I agree that this agreement remains in effect until canceled by Administrative Concepts, Inc. my financial institution or me. I have a copy of this agreement and I know I can also contact Administrative Concepts, Inc. or its agent for a copy.

PLEASE ATTACH A VOIDED CHECK

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: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ <input type="checkbox"/> Exempt payee <input type="checkbox"/> Other (see instructions) ▶	
	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.

Social security number
or
Employer identification number

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

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 ▶
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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,