UnitedHealthOne

PROSPECTIVE PRODUCER APPLICATION

Sub-Producer of Key/FMO Name Philip Roesel

Key/FMO No.AA0811561

Full Legal Name _____ I prefer to be called: _____

Business Street Address (Required for Supplies) _____

Business Mailing Address _____

City _____ County _____ State _____ ZIP_____

Business Phone (____) _____ Fax (____)_____

E-mail _____

Home Address _____

City _____ County _____ State _____ ZIP _____

Home Phone (____) _____ Birth Date _____ Gender _____

Social Security No. _____ National Producer No. _____

Length of time in present community _____. If less than five years, please provide previous address(es).

Please answer all questions. (If YES, include details of who, what, when, and dollar amounts on an additional form.)

	YES	NO
1. Have you ever had an appointment terminated by any insurance company or financial services institution (for reasons other than production)?	☐	☐
2. Do you owe any debt or balance to any insurance company or financial services institution that has remained overdue for more than sixty (60) days?	☐	☐
3. Has any state or federal agency ever denied, suspended, revoked, or taken any action against any fiduciary license held or applied for by you, or have you ever voluntarily submitted to any sanction or surrendered any fiduciary license under threat of suspension or revocation of that license?	☐	☐
4. Has any state or federal self-regulatory body of any type (such as National Assn. of Securities Dealers) ever taken any disciplinary measures against you?	☐	☐
5. Have you ever had a claim filed against your Errors and Omissions Coverage, or has any bonding company ever denied, paid out on, or revoked a bond for you?	☐	☐
6. Have you ever been the subject of any civil or administrative proceeding, including one initiated by a state department of insurance?	☐	☐
7. Do you have any felony charges pending against you, or have you ever pled guilty or nolo contendere to or been convicted of a felony or a crime involving moral turpitude?	☐	☐
8. Do you have any unsatisfied liens (tax or otherwise) or judgments (civil or otherwise) against you?	☐	☐
9. Have you been the subject of a bankruptcy petition or proceeding in the past seven (7) years?	☐	☐

(1) I hereby represent that the answers and statements ("the information") I am giving UnitedHealthcare Life Insurance Company and its affiliates ("the Company") on this application ("PPA") are correct, complete, and wholly true. **(2)** I understand the Company will rely on the information as one factor in considering this PPA, and may, at its option, terminate or rescind our resulting business relationship if any of the information is not as I have given it. **(3)** I give the Company, its employees, agents, and/or contractors permission to direct advertising or promotional phone calls, faxes, and electronic mail to the numbers and addresses listed above, as well as any others I provide. This permission continues until specifically revoked by me in writing. **(4)** I understand this PPA will not be considered until I sign the FCRA Authorization.

Signature X _____ **DateX** _____

NOTE: No business may be solicited until all state licensing and appointment and/or requirements have been met, and you have been advised that fact in writing by the Company.

DISCLOSURE

UNITEDHEALTHCARE LIFE INSURANCE COMPANY AND/OR ANY AFFILIATED COMPANY (COLLECTIVELY, "THE COMPANY") MAY OBTAIN CONSUMER REPORTS AND/OR INVESTIGATIVE CONSUMER REPORTS ABOUT YOU IN CONNECTION WITH YOUR CONTRACT REQUEST, AS WELL AS ANY SUBSEQUENT REQUESTS.

AUTHORIZATION

I authorize The Company to conduct a public records search, and/or to obtain a consumer reports, and/or an investigative consumer reports about me from a consumer reporting agency. These reports may concern my credit history, worthiness, standing, and/or capacity. These reports may also concern my character, general reputation, personal characteristics, criminal, and civil history, and/or mode of living. I understand that The Company will use this information in whole or in part as a factor in considering my initial contract or any subsequent changes in my relationship with The Company.

I understand that if The Company decides not to approve my contract/request and thereby to take adverse action against me because of information contained in any consumer report(s) authorized by my signature on this form, The Company will provide to me:

- A written pre-adverse action disclosure;
- An adverse action notice;
- A copy of any consumer report(s) received and used by The Company;
- A copy of "A Summary of Your Rights Under the Fair Credit Reporting Act"; and
- The name, address and telephone number of any consumer reporting agency that furnished a consumer report about me to them.

I understand that I am entitled to contest the accuracy or completeness of information contained in any consumer report. I understand that I am entitled to receive an additional free copy of any consumer report. I understand that the consumer reporting agency does not itself make any decision regarding my request with The Company, and the agency cannot explain The Company's decision to me.

A photocopy or fax copy of this authorization shall be as effective as the original. This permission continues until specifically revoked in writing by the person who signs below.

Printed Name **Social Security Number**

Signature **Date**

Address

City **State** **ZIP Code**

PROFILE INFORMATION

1. Over the past 12 months, what percentage of total revenue from your current insurance business does individual health represent? (Check one.)

❑ 0%-10% ❑ 11%-24 ❑ 25%-49% ❑ 50% or more

2. What type of insurance is your <u>primary</u> line of business? (Check one.)

❑ Annuities/LTC
❑ Disability Income Insurance
❑ Financial Services
❑ Group Health
❑ Individual Health
❑ Life
❑ Medicare Business (Part D, Supplement, etc.)
❑ Property/Casualty
❑ Supplemental Policies (Accident, Dental, Vision)
❑ Other

3. How many new individual health applications did you personally write in the past 12 months with all carriers combined—excluding Short Term, Medicare Plans, Employer, and Employer/Group policies? (Check One.)

❑ 0
❑ 1-5
❑ 6-10
❑ 11-2
❑ 21-50
❑ 51-100
❑ 101-200
❑ 201+

4. How many do you plan to write over the next 12 months? (Check one.)

❑ More
❑ Same
❑ Less

5. Which of the following carriers do you consider to be the primary and secondary recipients of your new individual health applications? Please mark your primary carrier with the number 1, and your secondary carrier with the number 2. <u>Please mark 1 and 2 ONLY.</u>

___Aetna
___American Community
___American Medical Security
___Assurant/Fortis/Time
___Blue Cross Blue Shield/ Anthem/Wellpoint
___Celtic
___Cigna
___Coventry/Health America
___Golden Rule/UnitedHealth One/UnitedHealthcare
___Health Net
___Humana One
___Kaiser Permanente
___Mega Life and Health
___Medical Mutual
___PacifiCare
___World Insurance
___Unicare
___None
___Other _____

6. Over the past 12 months, how many of the following products have you personally written?

Short Term Medical Plans
- ❑0
- ❑1-9
- ❑10-24
- ❑25+

Medicare Plans (Supplements, Advantage Plans or Part D)
- ❑ 0
- ❑1-9
- ❑10-24
- ❑ 25+

Health Savings Accounts (HSAs)
- ❑0
- ❑1-9
- ❑10-24
- ❑ 25+

Dental (standalone) Insurance Plans
- ❑ 0
- ❑ 1-9
- ❑ 10-24
- ❑ 25+

Accident (standalone) Insurance Plans
- ❑ 0
- ❑ 1-9
- ❑ 10-24
- ❑ 25+

Critical Illness (standalone) Insurance Plans
- ❑ 0
- ❑ 1-9
- ❑ 10-24
- ❑ 25+

7. How many states are you licensed in for health insurance?
- ❑ 1
- ❑ 2-4
- ❑ 5-9
- ❑ 10 or more

PPA Explanation Page

This page is required for any of the questions that have a "yes" answer on the Prospective Producer Application. A detailed explanation is needed and should include who was involved, when it occurred, dollar amounts, detailed information as why it occurred and steps taken to resolve issue.

Producer Name: _____

Producer number: _____

Question # _____

_____

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_____ _____

Producer Signature Date

-SIGN AND RETURN THIS SIGNATURE PAGE-

INDEPENDENT PRODUCER'S CONTRACT
SIGNATURE PAGE

I acknowledge and agree that:

(a) I have received a copy of the Independent Producer Contract (IPC-1213),

(b) I have read, understood, and agreed to each and every term of the Contract, any and all provisions of which provisions of which cannot be altered without the express written consent of UnitedHealthcare Life; and

(c) This Contract will not be in effect until such time as UnitedHealthcare Life has countersigned this Signature Page.

(d) The Contract may be executed in two or more counterparts, any of which need not contain the signature of more than one party, but all such counterparts when taken together will constitute one and the same agreement.

YOU: X _____

Print or type your name

X _____ **X** _____

Your signature **Date**