FMO Relationship Hierarchy Addendum

UnitedHealthcare® Medicare Solutions

THIS IS A WRITABLE FORM*

Please type in the information below. Use the Tab key to move through the fields.

Please complete and attach this page for all producer transactions.

☑ Onboarding ☐ Change in Hierarchy ☐ Add Appointment State(s)	Client Reference # (If Applicable)
FMO Name/Entity: Premier Senior Marketing Inc	FMO#: 620000
SGA Name/Entity: GoHealth	SGA#: 2079729
~~MGA Name/Entity~~	~~MGA#~~
~~GA Name/Entity~~	~~GA#~~
~~Agent Name~~	~~AGT#~~
Solicitor Name	SOL#
FMO Signature	Date

Check the following appointment level:

☐ ~~FMO~~ ☐ ~~SGA~~ ☐ ~~MGA~~ ☐ ~~GA~~ ☐ ~~AGT~~ ☑ SOL

Please appoint to the following states (check all that apply):

UnitedHealthcare Medicare Solutions covers the cost to appoint producers in their resident state. Where applicable, non-resident appointment fees will be deducted from the producer's commissions.

☐ AK	☐ AL	☐ AR	☐ AZ	☐ CA	☐ CO	☐ CT	☐ DC	☐ DE	☐ FL
☐ GA	☐ HI	☐ IA	☐ ID	☐ IL	☐ IN	☐ KS	☐ KY	☐ LA	☐ MA
☐ MD	☐ ME	☐ MI	☐ MN	☐ MO	☐ MS	☐ MT	☐ NC	☐ ND	☐ NE
☐ NH	☐ NJ	☐ NM	☐ NV	☐ NY	☐ OH	☐ OK	☐ OR	☐ PA	☐ RI
☐ SC	☐ SD	☐ TN	☐ TX	☐ UT	☐ VA	☐ VT	☐ WA	☐ WI	☐ WV
☐ WY	Territories: ☐ USVI	☐ PR	☐ Guam	☐ American Samoa					

For Internal Use: Broker Sales Review (FMO and SGA only)

UHC Authorization	Date
Print Name	

PLEASE SEND THIS DOCUMENT TO:

EMAIL: uhpcred@uhc.com ○ **Fax:** 1-888-205-7375

Appointment Application

UnitedHealthcare Insurance Company and Affiliates

UnitedHealthcare Medicare Solutions

THIS IS A WRITABLE FORM*

Please Print or Type: All fields must be complete and legible

Individual Information (All Individual Information fields required for all Appointment Applications).			
Legal Name (As name appears on Individual Resident State Insurance License) Last: Middle First:			
Social Security Number	Birth Date (MM/DD/YYYY)	Alias/Other Names:	
Resident Address			
City	State	County (FL Only)	Zip Code
Resident Phone Number	Business Phone Number	Fax Number	
Email Address			
Appointment Type: ☐ Individual OR ☐ Corporation	This must match information provided on the Agreement and W-9.		
Mailing Preference: ☐ Residential OR ☐ Business	If applying as an individual, but prefer mail be delivered to your business, fill in the Business Address section below.		

If Applying as a Corporation, the following information is also required. (You must be a Principal of the Corporation to Apply).			
Corporation Name	Principal		
Corporate Tax ID	Business Phone		
Business Address			
City	State	County	Zip

Errors and Omissions Attestation of Coverage ($1,000,0000 per occurance or 1,000,000 annual aggregate required)	
Name of Carrier	Policy #

By signing this attestation I am agreeing that I have met, and will maintain, the required Errors and Omissions coverage during my contract with UnitedHealthcare. I understand that failure to have met and maintained the Errrors and Omissions coverage requirements will result in immediate termination.

Applicant's Signature: _____ SIGNATURE

Version
06/16

NOTE: Failure to accurately and honestly answer any of the following questions may result in a declination of your application and appointment with UnitedHealthcare

If you answer "Yes" to any of these questions, please provide supporting documentation and a brief explanation on the next page of this form.

Criminal Background Information

1. Have you ever been convicted of a felony? ☐ Yes ☐ No
2. Have you ever been convicted of a misdemeanor (other than traffic) including an alcohol or drug-related offense? ☐ Yes ☐ No
3. Have you had your driver's license revoked within the past three years? ☐ Yes ☐ No

Department of Insurance and CMS

4. Have you ever had your insurance or securities license revoked and/or suspended by any department of insurance (even if later reinstated) for any reason? ☐ Yes ☐ No
5. Have you ever had a complaint reported against you (even if dismissed) by a consumer and/or insurance company for any reason with any department of insurance, FINRA, or other regulatory reporting agency including CMS? ☐ Yes ☐ No
6. Have you ever paid a fine related to a consumer complaint, failure to renew your license or continuing education credit in excess of $500? ☐ Yes ☐ No
7. Have you ever been excluded, or are you aware of actions that could result in an exclusion, by the Office of Inspector General from participation in a government health care program, including Medicare and Medicaid? ☐ Yes ☐ No

Credit History

8. Have you filed for bankruptcy and/or had a bankruptcy discharged within the last five years? ☐ Yes ☐ No
9. Are you, at the present time, or have you been within the past five years, involved in any civil litigation, judgements, liens orforeclosures? ☐ Yes ☐ No
10. Are you, at the present time, or have you been within the past five years, reported as delinquent on state or federal taxes? ☐ Yes ☐ No

Other Companies

11. Do you owe any insurance company, marketing organization or individual for any premiums collected or monies advanced? ☐ Yes ☐ No
12. Have you ever been denied an appointment with any insurance company? ☐ Yes ☐ No
13. Have you ever been terminated for cause by any insurance carrier? ☐ Yes ☐ No
14. Have you been denied a bond or application for errors and omissions (E&O) coverage with any company ☐ Yes ☐ No

Other

15. Do you have other information related to criminal, insurance-related complaints, credit, etc., that was not covered by these questions that you wish to disclose? ☐ Yes ☐ No

Please provide an explanation for any "Yes" answers on the previous page in the corresponding sections below.

Criminal Background Information

Department of Insurance and CMS

Credit History

Other Companies

Other

Last Name:

Conditions and Agreements

I have thoroughly reviewed this application and have answered all questions to the best of my knowledge. By signing below, I hereby attest to all matters set forth above and agree to all matters set forth below.

I hereby agree that if and when any or all of the companies issue to me any Agreement(s) for which I hereby apply, I will be bound by such Agreement(s). I understand that my supervising office has specimen forms of the Agreement(s) on file and I have had the opportunity to review such Agreement(s). Submitting to the Company any application for insurance products, including but not limited to Medicare Advantage and Prescription Drug Plan, shall constitute my agreement to such Agreement(s) and all the terms, conditions and provisions set for therein.

I Acknowledge that by signing this Appointment Application and submitting any such insurance application for Insured Product, I have so agreed to the Agreement(s) and no future signature by me shall be necessary.

Disclosure

I have executed this Appointment Application as evidence of the understanding and acceptance of, and consent to its terms, and I agree that I will not solicit business until I receive notification from the Company that this acknowledgement has been approved and I have satisfied all the of certification requirements of the products I intend to sell.

I understand that as part of its approval process and throughout the term of my appointment with the Company, the Company may obtain an investigation consumer report to confirm information regarding my character, general reputation, credit history, personal characteristics, mode of living, criminal history, insurance licensing history, Office or Inspector General records and General Service Administrator excluded party records. I hereby authorize the Company to obtain such a report at any time after receipt of this Appointment Application and throughout the term of my appointment with the Company. The scope of this authorization is all-encompassing, allowing the Company to obtain from any outside organization all manner of investigative consumer reports now and throughout my appointment to the extent permitted by law.

I understand that failure to accurately and honestly respond to any of the questions or attestations may result in a declination of my application and appointment with UnitedHealthcare.

Applicant's Signature	Date (MM/DD/YYYY)	SIGNATURE

Please return all documents to your Recruiter for submission to UnitedHealthcare.