

Application for Agent Appointment



Required documents that you will need to attach when submitting this form:

- Copy of Florida Health Insurance License
- Completed and signed IRS W-9 form for payee
- Completed and signed direct deposit form for payee
- Signed Agent/Producer Agreement for selling Individual, Group or Medicare
- Copy of current Errors & Omissions certificate of coverage

I: AGENT INFORMATION (please print)

Full Name _____ Date of Birth ____/____/____
(Last, First, Middle)

S.S.# _____ FL Insurance License No. _____
(Please attach a copy of health license.)

Home Address _____

City _____ County _____ State _____ Zip _____ Home Phone Number _____

Business Address _____

City _____ County _____ State _____ Zip _____ Business Phone Number _____

E-mail Address (required) _____ Fax Number _____

II: AGENCY INFORMATION (please print)

Full Legal Name _____ Federal Tax ID # (FEIN) _____

DBA (if different from legal name) _____ Contact _____

Type: Individual/Sole Proprietor Corporation Partnership Limited Liability company
 Other (Specify) _____

Business Address _____

City _____ State _____ Zip _____ Main Business Phone, Ext. _____

Mailing Address _____

City _____ State _____ Zip _____ Phone Number, Ext. _____

E-mail Address (required) _____ Main Fax Number _____

III: COMMISSIONS PAYMENT INFORMATION

Pay commissions to: Agent Agency (Payee's name and SS# or FEIN # as indicated above must match the W-9. Please attach a copy of a completed W-9 form.)

If Agency is designated as payee, provide contact information for individual authorized to view or receive commission statements:

Name _____

Phone _____ E-mail _____

IV: BACKGROUND

The following questions are applicable to the agent/agency/corporation/partnership and to each of the partners, members, directors, officers, or agents individually. If the answer is "yes" to any of these questions, please provide complete details to the best of your knowledge:

1. Have you or any of the partners, directors, officers or agents within this corporation/partnership 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
2. Have you or any of the partners, members, directors, officers or agents within this corporation/partnership ever been refused a license to sell Insurance/HMO, or has a license to sell Insurance/HMO ever been suspended or revoked by any state?
 Yes No
3. Have you or any of the partners, members, directors, officers or agents within this corporation/partnership ever been convicted of a crime, whether felony or misdemeanor, other than a minor traffic violation?
 Yes No
4. Have you or any of the partners, members, directors, officers or agents within this corporation/partnership ever been employed by an Insurance/HMO company, or another organization providing for or assisting with administration of health care or other employee benefits, where the employment contract was terminated or non-renewed because of allegations of wrongdoing?
 Yes No
5. Have you or any of the partners, members, directors, officers or agents within this corporation/partnership ever surrendered any insurance or HMO license, whether voluntarily or involuntarily?
 Yes No
6. Are you or any of the partners, members, directors, officers or agents within this corporation/partnership currently a named party in any lawsuit?
 Yes No
7. Have you or your company ever declared bankruptcy, had a lien placed against you or your company, been a judgment debtor or had other problems with your or your company's credit history?
 Yes No
8. Do you currently have Errors and Omissions coverage?
 Yes No
Carrier Name: _____ Policy No: _____ Amount of E&O: _____
(Please attach copy of current E & O certificate of coverage.)

If you answered "yes" to any of questions 1-7, please give details and the current status below.

I hereby certify that I have read and understand the items on this form and that my answers are true and complete to the best of my knowledge. I have been advised that AvMed Health Plans (the Company) or any of its agents or subcontractors, may conduct certain investigations in connection with my request to represent the Company in the solicitation of AvMed products as described in the Agent/Producer Agreement. I hereby consent to the Company requesting and obtaining all information as discussed in this paragraph and for all such reports to be requested by and provided to the Company.

I understand that a routine inquiry may be made as a requirement for state appointment. If applicable, the Company may obtain reports from a consumer reporting agency, an investigation report or inquiries from a State Insurance Department. Any information that the Company obtains about me will be treated as confidential.

FAIR CREDIT REPORTING ACT: As part of its regular procedures, the Company may obtain an investigative consumer report. It may deal with character, reputation, personal traits and lifestyle. It may involve personal interviews with friends, neighbors and associates. I understand I have the right to make, within a reasonable amount of time, a written request for details on the name and address of the agency making the report. I further understand that, depending on the state law, subjects of an investigative consumer report may have the right to: 1) request that they be interviewed in connection with the making of the report; and 2) receive a copy of the report, upon request. My signature below constitutes my agreement and authorization to the above.

In signing this application I certify that I have not been convicted of any criminal felony involving dishonesty or breach of trust or been convicted of an offense under section 1033 of the Violent Crime and Law Enforcement Act of 1994. I further agree to immediately inform AvMed of any conviction of the types described in the preceding sentence.

I agree to abide by the Disclosure Requirements mandated by the states in which I operate. I understand and agree to follow the guidelines of the Health Insurance Portability and Accountability Act (HIPAA) and Gramm-Leach-Bliley Act (GLBA), which are contained in the AvMed Agent/Producer Agreement.

I understand that if any of the information I provided is found to be incorrect or incomplete, at the discretion of the Company, it may be grounds for non-appointment or immediate termination of my appointment and the Agent/Producer Agreement.

Agent/Producer agrees to be familiar with, and abide by, the requirements of Florida law outlawing multiple employer welfare arrangements and other illegal health insurers, and will comply with continuing education requirements.

Signature of Agent/Producer

Date

Printed Name

Title

Internal Use Only

Appointment denied, by: _____ Date: _____

Appointment approved, by: _____ Date: _____

Appointment submitted to DFS by: _____ Date: _____

Line of Business: Commercial _____ U65 _____ Medicare _____