



# Appointment Application Field Marketing Organization (FMO) Channel United Healthcare Insurance Company and Affiliates

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

Type of Request: NEW \_\_\_\_\_ CHANGE \_\_\_\_\_

<b>Individual Information</b> (All Individual Information Fields Required for All Appointment Applications)				
Legal Name (As it appears on your Individual Resident State Insurance License)			Alias/Other Names	
Social Security #			Date of Birth	
Home Address				
City		State	County	Zip
Home Phone		Business Phone		Fax
E-mail Address (required)				

Appointment Type: <input type="checkbox"/> Individual    OR <input type="checkbox"/> Corporation <small>This must match information provided on Agreement and the W-9.</small>	Mailing Preference: <input type="checkbox"/> Home    OR <input type="checkbox"/> Business <small>If applying as an Individual, but prefer mail be delivered to your business, fill in the Business Address section below.</small>
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**If applying as a Corporation, the following information is also Required** (Please note that you must be a Principal of the Corporation to apply as such)

Corporation Name		Principal		
Corporate Tax ID		Business Phone		
Business Address				
City		State	County	Zip

Please list the states for which you are applying for appointment:	*Must include resident state *Must be licensed in each state listed	*All states subject to individual review *Listing a state does not guarantee appointment for that state
Resident State:	Non-Resident States:	

**Errors and Omissions Coverage**

**AN ACTIVE POLICY DECLARATION PAGE WITH YOUR NAME LISTED AS THE COVERED ENTITY MUST BE ATTACHED**

Name of Carrier \_\_\_\_\_

Policy # \_\_\_\_\_ Expiration Date \_\_\_\_\_  
 (\$1,000,000 per occurrence and \$1,000,000 annual aggregate required)



# Appointment Application

## Field Marketing Organization – FMO Channel

### United Healthcare Insurance Company and Affiliates

**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 a separate sheet of paper.**

#### **Criminal Background Information:**

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

#### **Departments of Insurance and CMS:**

4.  Yes  No 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?
5.  Yes  No 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, NASD, or other regulatory reporting agency including CMS?
6.  Yes  No Have you ever paid a fine related to a consumer complaint, failure to renew your license or continuing education credit in excess of \$500?
7.  Yes  No 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 or Medicaid?

#### **Credit History:**

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

#### **Other Companies:**

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

#### **Other:**

1.  Yes  No 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?



**Appointment Application Field Marketing  
Organization – FMO Channel  
United Healthcare Insurance Company and Affiliates**

**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 forth 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 of the certification requirements for the products I intend to sell. I understand that as part of its approval process, the Company may obtain an investigative consumer report which will confirm information regarding my character, general reputation, credit history, personal characteristics and mode of living. I hereby authorize the Company to obtain such a report.

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please return all documents to your Field Marketing Organization (FMO)  
Recruiter for submission to UnitedHealthcare.**



## 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"/> Other ▶ .....	<input type="checkbox"/> Exempt from backup withholding
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. person (including a U.S. resident alien).

**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 ▶

### 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.

**U.S. person.** 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.

In 3 above, 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.

For federal tax purposes, you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

**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,



## Electronic Fund Transfer

SecureHorizons will deposit your check directly to your bank account. We make the deposit according to the current Commission Deposit Schedule. Below is an authorization form so that you may sign up for this service. Just complete the form and mail it back with your appointment paperwork.

### Fund Transfer Authorization

I (We) do hereby authorize the deposit of all commission payments due me (us) to my (our) checking account indicated below and the Depository Financial Institution named below to credit the payment (s) to such account by SecureHorizons.

Account Number: \_\_\_\_\_

Financial Institution Name: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

I (We) reserve the right to revoke and cancel this authorization, such revocation and cancellation to take effect upon written notice received at the office of SecureHorizons with reasonable time to act on such notice.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Agent Number

\_\_\_\_\_  
Agent Signature

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ATTACH VOIDED CHECK HERE  
(DEPOSIT SLIPS ARE NOT ACCEPTABLE)



**United Healthcare Insurance Company  
Assignment of Commissions**

To \_\_\_\_\_ Tax ID \_\_\_\_\_  
(Herein called the Assignee)

Assignee's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone \_\_\_\_\_

For valuable consideration, the undersigned, herein called the Assignor, hereby assigns to the Assignee all of the Assignor's right, title, interest, claim or demand in and to any and all compensation now due and payable, or which may become due and payable, under existing contracts and agreements heretofore entered into by and between United Healthcare Insurance Company, on behalf of itself and its affiliates (collectively, the "Company") and Assignor.

Assignor hereby authorizes and empowers the Company to pay Assignee all compensation (including but not limited to over-riding commissions) now due or which may become due under the Agreement until such time as Assignor terminates this assignment by written notice to the Company. Assignor acknowledges and agrees that such payment of compensation to Assignee shall constitute payment of such compensation to the Assignor as if paid directly to the Assignor and the Company shall be fully released from any and all responsibility to the Assignor for such payments. Assignor hereby acknowledges and agrees that assignment of compensation payable under the agreement does not release or otherwise relieve

Assignor of any obligation or responsibility under the Agreement including, but not limited to, the obligation to pay commissions to Solicitor Agents and/or the obligation to reimburse the Company for compensation paid on premiums subsequently refunded.

Assignor hereby covenants and agrees that Assignor is the absolute and sole owner of said compensation, free from assignment or encumbrance of any kind or character whatsoever, and has full right and lawful authority to so assign same. The Assignor shall at all times defend, indemnify and hold harmless the Company and its officers, agents, and employees form and against any and all suits, actions, losses, damages, claims, expenses (including but not limited to the Company's legal expenses) and liability of any character, type of description arising out of the execution or performance of this assignment.

Assignor Signature \_\_\_\_\_ Dated \_\_\_\_\_

Assignor Name \_\_\_\_\_  
(Print)

Assignee Signature \_\_\_\_\_ Dated \_\_\_\_\_

The Company acknowledges receipt of, and consents to the foregoing assignment, but assumes no responsibility for the validity or sufficiency hereof. This assignment is effective on the date signed by an authorized officer of the company.

By \_\_\_\_\_ Dated \_\_\_\_\_  
(Authorized Company Signature)

Company Officer Name \_\_\_\_\_ Title \_\_\_\_\_  
(Print)

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