SENIOR MARKETING INSURANCE GROUP INC©

Contracting Checklist of Medico

In order to complete the contracting process, please closely follow the checklist below. Each question MUST BE ANSWERED on all forms including correspondence to 'yes' answered background questions. If a question does not apply to you, place the abbreviation "N/A" in the blank.

- Signed and Completed Confidential Personal history Form
- Signed and Completed Distributor Agreement (*Include Voided Check*)
- Signed and Completed Business Associate Agreement
- Signed and Completed Acknowledgement of Receipt Producer Life Replacement Policies and Procedures
- Signed Advance Agreement
- Send a copy of your CURRENT LICENSE! *(Send a copy of your agency license if appointing as a corp.)*

Send the above information to SMiG:

By Email: contracts@smig-inc.com

By Fax: 314-685-8013

By Mail: Senior Marketing Insurance Group
712 N 2nd St, Suite 310
Saint Louis, MO, 63102

The licensing process cannot begin until all of the above items have been received!!! If you have any questions, please call us at:
866-345-0109.

MEDICO™ GROUP

Medico™ Insurance Company
1515 South 75th Street • Omaha, Nebraska 68124

CONFIDENTIAL PERSONAL HISTORY

PERSONAL INFORMATION:

Name _____ Social Security No._____ - _____ - _____
First M.I. Last Suffix

Date of Birth _____ Sex _____ Maiden or Other Name Used _____ Spouse's Name _____

Home Address _____ _____ _____ _____
Street Apt. No. City State Zip Code

Mailing Address _____ _____ _____ _____
Street Apt. No. City State Zip Code

UPS Address _____ _____ _____ _____
Street Apt. No. City State Zip Code

Business Phone No. (_____) _____ - _____ Home Phone No. (_____) _____ - _____

E-Mail Address:_____ Fax No.: (_____) _____ - _____

IMPORTANT!! E-MAIL ADDRESS IS REQUIRED FOR WEBSITE SIGN ON AND FOR COMMUNICATION FROM HOME OFFICE

TYPE OF CONTRACT:

If you are seeking an appointment on behalf of an agency, is that agency a:

☐ Sole Proprietorship ☐ Partnership ☐ Corporation

FEDERAL I.D. NO. _____

Is the agency now licensed? ☐ YES ☐ NO

Please list all partners or corporate officers:

NAME	TITLE	SOCIAL SECURITY NO.

LICENSE INFORMATION:

Are you now licensed? ☐ **YES** ☐ **NO**

If yes, please indicate below any license(s) you currently hold:

RESIDENT STATE	LICENSE OR QUALIFICATION NO.	TYPE OF LICENSE/LINES

NONRESIDENT STATE(S)	LICENSE OR QUALIFICATION NO.	TYPE OF LICENSE/LINES

WORK HISTORY:

(Please begin with most current employer.)

EMPLOYER/ADDRESS	SUPERVISOR NAME	POSITION HELD	DATES	PHONE NUMBER
			FROM TO	(___) ____- _____ Ok to contact? _____
			FROM TO	(___) ____- _____ Ok to contact? _____
			FROM TO	(___) ____- _____ Ok to contact? _____

Please answer the following questions:

Has any state ever taken administrative action against your license? _____ If so, name state and provide details: _____

Have you ever been convicted of a felony? _____ Details: _____

_____

Have you ever been short in accounts with any employer or do you currently have a debit balance with any insurance company? _____ If so, please explain: _____

_____

Have you ever been refused bond? _____ If so, please explain: _____

_____

Have you ever filed for bankruptcy? _____ If so, please explain: _____

_____

Do you have any judgments or garnishments against you? _____ Please explain: _____

_____

Have you been or are you involved in any litigation? _____ Please explain: _____

_____

I certify that my answers to the above questions are true and authorize the State Insurance Department to release to Medico™ Insurance Company information within their records concerning me. If accepted, I will comply with all regulations of this State and Medico™ Insurance Company and will not solicit insurance until I have received my license from the State Insurance Department.

I hereby authorize an investigative and credit report whereby information is obtained through personal interviews; the inquiry usually concerns information on your character, general reputation and mode of living. I understand that any information obtained by the Company will be available to me upon my written request.

Applicant Signature _____ **Date** _____

This applicant is recommended for appointment as a Distributor assigned to my jurisdiction, subject to the terms of my contract with the Company. I certify to the best of my knowledge the applicant is of good personal and business reputation, trustworthy, and competent to act in the capacity of an insurance agent.

Recruiting Distributor Signature _____ SIGN HERE **Date** _____

Request Background Investigation? ☐ **YES** ☐ **NO**

MEDICO™ GROUP

Medico™ Insurance Company
1515 South 75th Street, Omaha, Nebraska 68124

Distributor Direct Deposit Authorization

Instructions
Please complete Parts A through C, attach a voided check, and return to the Home Office with your contracting papers.

Part A: Bank Account Holder Personal Information – Please Print

Name_____

Address_____
Street Address City State Zip

Phone No._____ E-mail Address_____

Part B: Bank Account Information

Start Direct Deposit ❒ Change Account Information ❒

Please Attach A Voided Check

Checking ❒ Savings ❒

Routing Number | | | | | | | | | |

Account Number | | | | | | | | | | | | | | | | | |

Part C: Bank Account Holder(s) Signature(s)

I (We) give permission to Medico™ Insurance Company to automatically make payments to my (our) bank account of my commissions. This authorization will remain in force unless I (we) cancel it or my (our) bank account is closed.

Signature_____ SIGN HERE Date_____
As it appears on bank records.

Printed Name_____

Signature_____ Date_____
If joint account.

Printed Name_____

DISTRIBUTOR AGREEMENT

This Agreement entered into between Medico® Insurance Company, on the one part, and the undersigned Distributor, on the other part.

DEFINITIONS: As used in this Agreement,

A. "We," "Us," "Our," "Company," and "Medico®" mean Medico® Insurance Company.
B. "You," "Your," and "Yours" mean the Distributor, even though Distributor may be a partnership or corporation.
C. "Solicitor" means an insurance producer who is appointed by Us, but not contracted with Us.

1. **APPOINTMENT:** We appoint You as Our Distributor to procure applications for health and life insurance of Medico® if You are licensed to sell these lines of insurance. This appointment is on a non-exclusive basis and We may appoint other distributors in Your state.

AS DIRECTED BY US

2. **YOUR DUTIES:** You agree to accept the following duties and responsibilities:

A. You and Your Solicitors will procure applications for Our insurance. In doing this, You and Your Solicitors will act according to Our rules and instructions.

B. Unless there is something that would disqualify them, We will appoint Your Solicitors. We reserve the right to terminate Your Solicitors. We shall have no liability to any of Your Solicitors for their compensation or otherwise. You agree that Your contracts with each of Your Solicitors for Our insurance will not entitle the Solicitor to a greater dollar amount of compensation, nor for a longer period of time, than You are entitled to from Us on such business. If You violate this agreement, You will, at Our option, lose all commissions which are due You thereafter.

C. You will not permit any of Your Solicitors to solicit for Us until they have been licensed by the state in which they will solicit and evidence of that license is given to Us.

D. You will collect in full the first premium with the application on each policy You or Your Solicitors sell. You will treat these premiums as trust funds for Us. You will remit these funds and applications to Medico® in accordance with Our instructions.

E. You will comply with all state and federal laws, orders, rules and regulations.

F. You will be responsible for obtaining and maintaining the necessary licenses and appointments to sell Our products in the states in which You operate, whether resident or nonresident. You will be responsible for all state and city license fees or taxes, applicable appointment and termination fees, and occupation fees or taxes. We will pay state taxes on premiums.

G. You will reimburse Us any commissions You receive on premiums which are returned by Us on declined applications or policies canceled or not accepted by the applicant.

H. You will see that You and each Distributor and/or Solicitor has and maintains or is covered by errors and omissions liability insurance coverage of at least $1 million per occurrence or such other level (higher or lower) as may be acceptable to Us throughout the term of this Agreement and provide evidence of such insurance to Us upon request.

3. **LIABILITY, INDEBTEDNESS & INDEMNITY:** You shall be jointly and severally liable, with each Distributor and/or Solicitor, to Company for the payment of all (i) monies due from You or Your Distributors and/or Solicitors, (ii) debit balances on the account of You or Your Distributors and/or Solicitors, (iii) debit balances resulting from loans to You or Your Distributors and/or Solicitors, and (iv) all obligations evidenced by documents related hereto. Company's books shall be prima facie evidence of such debit balances or loans due.

Any indebtedness incurred by You or Your Distributors and/or Solicitors to Company shall be payable immediately upon receipt of a written notice from Company. Company may, at any time in its sole discretion, offset against any remuneration due or to become due You, any past, present or future debt or debts due from You or Your Distributors and/or Solicitors. Such indebtedness of You or Your Distributors and/or Solicitors shall be secured by a first lien in favor of Company on any and all compensation due You and shall be binding upon You and Your assigns and successors. Upon the termination of this Agreement, any and all money belonging to Company in the possession of You or Your Distributors and/or Solicitors shall immediately become due and payable and shall be paid over to Company; but Company may, in its sole discretion and without waiving its rights, deduct such indebtedness from any payment provided herein until repaid.

You agree to indemnify Company and its affiliates, shareholders, directors, officers and employees and to hold Company, its affiliates, shareholders, directors, officers and employees harmless from any and all expenses, liabilities, costs, cause or causes of action and damages, including attorneys' fees and costs of litigation, resulting from or growing out of any breach of this Agreement or any related documents or any unauthorized, fraudulent, negligent or wrongful act, omission, statement or representation by You or Your employees or independent contractors (excluding Distributors who are directly contracted with the Company). Company agrees to indemnify You and to hold You harmless from any and all expenses, liabilities, costs, cause or causes of action and damages, including attorneys' fees and costs of litigation, resulting from or growing out of any negligent or wrongful act, omission, statement or representation by Company or Company's employees. This Section 3 shall survive the termination of this Agreement for any reason.

4. **COMPENSATION:** You will be paid the commissions stated in the Commission Schedule, which is attached hereto, as complete compensation for all that You and Your Solicitors do for Us. The attached Commission Schedule may be revised from time to time to reflect policies presently being marketed by Medico®. Where a policy is delivered or issued for delivery in any state listed under the heading "State Variation," the commission for that particular state will apply.

5. **COMMISSIONS ON SUBSTITUTED OR REINSTATED POLICIES:** When You substitute one policy for another, Your commission will be governed by Our rules and regulations regardless of what this Agreement says. When We reinstate or reissue a lapsed policy without Your efforts and this occurs during the first six months after the policy lapses, We will pay You commissions on the premiums received for this policy after reinstatement or reissue at the renewal commission rate for that policy. When You reinstate or rewrite a policy during the first six months after the policy lapses, We will pay You a commission on the premium You collect at time of reinstatement or rewrite equal to one-half the regular first-year commission rate for that policy. We will pay You commissions on subsequent premiums for the reinstated or rewritten policy at the renewal rate in effect at that time for the policy. During the 60-day period following the due date of a policy, it must be reinstated and You cannot rewrite it. During the period which starts 60 days after a policy's last premium due date and ends four months later, You may either rewrite the policy or reinstate. After a policy has been lapsed for a period of six months, You must rewrite the policy. It cannot be reinstated.

6. **YOUR STATEMENT:** We will send You a statement or transmit an electronic statement to You showing Your account with Us. However, no statement will be sent when Your account with Us is zero. If You die, We will send this information to Your spouse or Your estate. You agree that each statement will be binding on You, Your spouse and Your estate unless You, Your spouse or Your estate tells Us, within 45 days after the statement is transmitted, that the statement is wrong.

7. **ASSIGNMENT:** You cannot assign this Agreement or any amount We owe You without getting Our written consent first. If You do, the assignment shall not be valid. If We consent to an assignment by You of the commissions due under this Agreement, the assignment shall be subject to any amount You owe Us at the time of the assignment. The assignment shall also be subject to any amount You may owe Us in the future. If We consent to an assignment by You of this Agreement, You shall remain liable for the performance of the terms of this Agreement by the person or business entity who receives the commission assignment from You.

8. **LIMITED AUTHORITY:** You will not accept any risks, change any policies, make any contracts for Us or obligate Us in any way unless You secure Our written consent first. You will not change any premium rates or extend the time for paying premiums. You will not accept applications for any policies without collecting the entire premium due at the time of sale.

9. **LICENSES:** This Agreement will end for Medico®. if it does not continue to be licensed in the state covered by this Agreement. If You give up or lose Your license, this Agreement will end. If You are not licensed to sell both health and life insurance, this Agreement will apply only to that line of insurance for which You are licensed. If You later become licensed to sell either health or life insurance, this Agreement shall also apply to such additional line of insurance.

10. **ADVERTISING:** You will not use any advertising or any material not furnished by Us without getting Our written consent first. All representations or references to Medico® Insurance Company, its products or producers, in any advertisement or marketing material shall be submitted to Us prior to its use or distribution and shall not be utilized until You receive written approval from Us. Advertising includes any material which is designed to create public interest in Medico® Insurance Company, its products or producers. This includes, but is not limited to, consumer material designed to induce the public to purchase, increase, modify, retain, renew or reinstate a policy or certificate as well as producer recruiting and training materials. Examples of advertising include, but are not limited to, printed and published material, business cards, audiovisual material, direct mail material, Internet sites, newspaper and magazine ads, radio and television scripts, billboards and similar displays, flyers and ad slicks, leaflets and booklets, brochures, newsletters, form letters, prospect letters, telephone scripts, lead-generating devices of all kinds, depictions and illustrations, prepared sales talks, presentations and producer training materials.

11. **COMMUNICATION AND TRANSPORTATION EXPENSES:** If We phone You or send anything to You, We pay the cost. If You phone Us or send anything to Us, You pay the cost.

12. **DECLINATIONS:** We shall have the right to decline an application without giving any reasons for doing so.

13. **FEDERAL, STATE AND LOCAL LAWS:** You agree to obey all federal, state and local laws and regulations.

14. **PROHIBITED ACTIONS:** You agree that You will not rebate in any form. You agree that You will not make any representations to any of Our policyholders to get them to terminate their insurance.

15. **RESERVATION OF RIGHTS:** We shall not be liable to You for exercising any of the rights given to Us in Our policies. Examples of these rights are the right to cancel or nonrenew the policy or to change the premium rates. We shall not be liable to You for withdrawing or substituting policy forms, nor for Our withdrawing entirely from any state. Further, We specifically reserve the right without limitation and without liability to You to change or discontinue any marketing concept or underwriting program in any state, change any policy premium rate, change the conditions or terms under which a policy may be offered, or reject any application or return any premium.

16. **VESTMENT:** Commissions provided for in this Agreement shall be paid for as long as the policy remains in force, subject to provisions of this Agreement providing otherwise in Paragraphs 17 and 18, herein. This provision shall survive the termination of this Agreement.

17. **TERMINATION:** You or We may terminate, without cause, this Agreement by giving at least 30 days notice to the other parties. You or either of Us may terminate this Agreement immediately for good cause by giving notice to the other party. Notice shall be given pursuant to the Notice provision of Paragraph 24, herein. Good cause shall mean:

A. Fraud or any breach of the terms of this Agreement.
B. Failure to pay any money required by this Agreement to be paid.
C. Violation of any federal, state or local laws or regulations.
D. Any act or omission by You which could affect the right of Medico® to do business in the state covered by this Agreement.
E. Inducing or attempting to induce policyholders to relinquish or replace Our policies with such frequency as to indicate a pattern of inappropriate activity.
F. Repeatedly failing to comply with material terms of this Agreement and/or Our stated rules and regulations concerning recruiting and production requirements for You or those under Your hierarchy.
G. Cause or attempt to cause employees or agents of Ours to discontinue their association with Us.
H. Misappropriation or commingling of Our funds.
I. Misrepresentation or omission of any material information on an application for a policy.
J. Misrepresentation of any of Our policies or services.

This provision shall survive the termination of this Agreement.

18. **FORFEITURE AND REMEDY:** You agree that after this Agreement ends, You will have no interest in any business written for Us, except as specifically provided in this Agreement. You agree that if You attempt to influence any of Our policyholders with whom You or Your Solicitors or Distributors have done business, or Our Solicitors, Distributors or employees, to terminate their contract or employment with Medico®, or this Agreement is terminated for good cause as defined in Paragraph 17, herein, You will lose all future commissions from Us. You also agree that We may secure a court order stopping You from using such influence since We do not have an adequate legal remedy. This provision shall survive the termination of this Agreement.

19. **MINIMUM AMOUNT OF COMMISSIONS:** After this Agreement terminates We will not pay commissions after any calendar year in which the total commission owed or paid to You is less than $500.00. If compensation due to You falls below the minimum required, such amount shall roll up to and be payable to the next level above You in the Distributor hierarchy.

20. **WAIVER:** The fact that We may not enforce the terms of this Agreement does not mean that We waive them or that We will not enforce them at a future time.

21. **RELATIONSHIP:** Nothing in this Agreement shall create a relationship of employee and employer, or a partnership, between You and Us. You are free to exercise Your own judgment as to the persons You solicit and where and when You solicit them. However, We may give instructions, which do not interfere with this freedom, regarding the conduct of Your business for Us and You will obey these rules.

22. **DISTRIBUTOR OR SOLICITOR TRANSFER:** The Company will permit a transfer of a Distributor or Solicitor to another organization pursuant to Our established policies and procedures.

23. **PRIVACY ACT NOTICE:** You herein acknowledge You have received a copy of the Privacy Notice of the Company. You acknowledge and agree You are acting as a third party services provider to the Company as contemplated in Section 503 of the Gramm-Leach-Bliley Privacy Act and are therefore bound by the stated policy of the Company regarding the release of nonpublic information derived by or for the Company in the normal course and conduct of business.

24. **NOTICES:** Any notice required by, or provided for, in this Agreement shall be considered given when it is mailed, postage prepaid, by certified or electronically confirmed mail, return receipt or electronic confirmation requested, and addressed to the party or parties at their last known address.

25. This Agreement shall be governed by and construed in accordance with the laws of the State of Nebraska. Any legal action necessary under this Agreement shall be brought in the District Court of Douglas County, Nebraska.

26. It is understood and agreed that no policy will be solicited or written until Distributor receives written notice that the plan is approved in the state in which solicitation is to be made.

27. This Agreement supersedes and replaces any previous agreements between You and Us.

(Please continue on next page.)

28. This Agreement is effective_____, 20____.

Accepted, agreed to and signed by the parties:

1. Distributor's Name_____
(Please Print)

_____
Taxpayer I.D. or Social Security Number

2. Distributor is:

Individual (Sole Proprietor)	( )
Partnership	( )
Corporation	( )

IF DISTRIBUTOR IS INDIVIDUAL OR SOLE PROPRIETOR:

BY:_____ SIGN HERE
(Signature)

IF DISTRIBUTOR IS PARTNERSHIP: (all partners must sign)

BY:_____ SIGN HERE
(Signature) (Printed Name)

BY:_____
(Signature) (Printed Name)

BY:_____
(Signature) (Printed Name)

IF DISTRIBUTOR IS CORPORATION:

BY:_____ SIGN HERE
(Signature & Title of Authorized Officer) (Printed Name)

Recommended By:

_____

Accepted:

MEDICO® INSURANCE COMPANY

By_____

Title Michael J. Leahy, Secretary

MEDICO™ GROUP

Medico™ Insurance Company
Medico™ Life Insurance Company
1515 South 75th Street • Omaha, Nebraska 68124

BUSINESS ASSOCIATE AGREEMENT

The undersigned on behalf of himself, his partnership or corporation (hereinafter referred to as "Business Associate") and Medico™ Insurance Company/Medico™ Life Insurance Company of Omaha, Nebraska, (hereinafter referred to "Covered Entity") in consideration of the mutual covenants, agreements, and promises hereafter contained and for good and valuable consideration, receipt of which is hereby acknowledged, do hereby agree as follows:

Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in the Privacy Rule.

Definitions

a. Business Associate. "Business Associate" shall mean the undersigned individual, partnership, or corporation.

b. Covered Entity. "Covered Entity" shall mean Medico™ Insurance Company/Medico™ Life Insurance Company.

c. Individual. "Individual" shall have the same meaning as the term "individual" in 45 CFR § 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).

d. Privacy Rule. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E.

e. Protected Health Information. For purposes of this Agreement, "Protected Health Information," as defined at 45 C.F.R. § 160.103, and as may be periodically revised or amended by the U.S. Department of Health and Human Services, the U.S. Congress or other federal agency, means information that is received from, or created or received on behalf of Covered Entity and is information about an individual which relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. Protected Health Information also either identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. Protected Health Information pertains to both living and deceased individuals. **Protected Health Information includes Electronic Protected Health Information as defined at 45 C.F.R. § 160.103 that is received from, or created or received on behalf of Covered Entity.**

f. Required By Law. "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR § 164.501.

g. Secretary. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.

1515 South 75th Street • Omaha, NE 68124 • ph 402-391-6900 • fax 402-391-6489
mail address: P.O. Box 3477 • Omaha, NE 68103 • www.gomedico.com

Obligations and Activities of Business Associate

a. Business Associate agrees to not use or disclose Protected Health Information other than as permitted or required by the Agreement or as Required by Law.

b. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.

c. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.

d. Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement of which it becomes aware.

e. Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity, agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.

f. Business Associate agrees to provide access, at the request of Covered Entity, during the normal business hours, to Protected Health Information in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 CFR § 164.524. If a Business Associate does not have Protected Health Information in a Designated Record Set this provision does not apply.

g. Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 CFR § 164.526 at the request of Covered Entity or an Individual, during normal business hours. If a Business Associate does not have Protected Health Information in a Designated Record Set this provision does not apply.

h. Business Associate agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, or to the Secretary or someone designated by the Secretary, during normal business hours for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.

i. Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.

j. Business Associate agrees to provide to Covered Entity or an Individual, during normal business hours, information collected in accordance with Section i, above, of this Agreement, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.

k. Business Associate agrees to implement administrative, physical and technical safeguards that will reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic Protected Health Information.

l. Business Associate shall report to Covered Entity any security incident relating to Electronic Protected Health Information of which it becomes aware. A security incident is defined at 45 C.F.R. § 164.304 as "the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system."

Permitted Uses and Disclosures by Business Associate

General Use and Disclosure Provision

Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in current or subsequent written agreements detailing the duties and obligations of the parties, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.

Specific Use and Disclosure Provisions

a. Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

b. Except as otherwise limited in this Agreement, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

c. Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information to provide Data Aggregation services to Covered Entity as permitted by 42 CFR § 164.504(e)(2)(i)(B).

d. Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with § 164.502(j)(1).

Obligations of Covered Entity

Provisions for Covered Entity to Inform Business Associate of Privacy Practices and Restrictions

a. Covered Entity shall notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information.

b. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes may affect Business Associate's use or disclosure of Protected Health Information.

c. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.

Permissible Requests by Covered Entity

Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

Term and Termination

a. Term. The Term of this Agreement shall be effective as of the date of execution and shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section.

b. Termination for Cause. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:

    1. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement and all other Agreements between the parties if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity;

    2. Immediately terminate this Agreement and all other Agreements if Business Associate has breached a material term of this Agreement and cure is not possible; or

    3. If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

c. Effect of Termination.

    1. Except as provided in paragraph (2) of this section, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

    2. In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon written notice that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

Miscellaneous

a. Regulatory References. A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended.

b. Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

c. Survival. The respective rights and obligations of Business Associate under Section c "Effect of Termination" of this Agreement shall survive the termination of this Agreement.

d. Interpretation. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule.

The undersigned on behalf of himself, the partnership, or corporation is executing this Agreement solely in reliance upon his own knowledge, belief and judgment, and not upon any representations made by the Covered Entity or others on its behalf.

I have read the foregoing Agreement and understand its terms and freely and voluntarily sign.

Dated at _____, this _____ day of _____, 20_____.

_____
(Signature)

_____
(Name)

_____
(Title)

_____
(Individual, Partnership or Corporation Name)

ACKNOWLEDGEMENT OF RECEIPT
PRODUCER LIFE REPLACEMENT POLICIES AND PROCEDURES

I acknowledge that I have received, read and will adhere to the guidelines stated in the Producer Life Replacement Policies and Procedures for Medico™ Insurance Company and Medico™ Life Insurance Company, Form U9F-4240. I understand that violating any of the stated policies or procedures will subject me to sanctions up to and including termination of appointment.

I am aware that I will not be eligible to solicit life insurance for the Company if this acknowledgement is not returned to the Company. When completed, please return this acknowledgement to: Marlene Albertsen, Manager of Agent Services, Medico™ Insurance Group, 1515 South 75th Street, Omaha, NE 68124. You may also fax the form to: Marlene Albertsen at (402) 398-0887.

Print Name _____ Producer Number _____

Agency Name (if applicable) _____ Date _____

SIGN HERE

Original Signature _____

Medico Advancing

- The advance will be for a total of 9 months
- Interest will be charged on the debit balance at 1% per month
- Advance commissions will only be offered on the POM modes
- Advance commissions will only be offer on the issued business

_____Yes, I would like to be paid a 9 month advance

_____ No, I would like to be paid “As Earned”.

_____

Signature