



Contracting Checklist for Americo

Please submit the following information and documents to **SMIG** when licensing with Americo:

- Completed and Signed Agent/Agency Application
- Completed and Signed Authorization for Disclosure of Agent Information
- Completed and Signed Guaranty Agreement
- Completed and Signed Commission Advance Addendum
- Completed and Signed Agent Agreement
- Completed and Signed EFT Direct Deposit form with Voided Check (required)
- Completed and Signed W-9
- Please submit all state licenses for the states you wish to be appointed

STATE LICENSING FEES MAY APPLY!!!

Send the above information to SMIG:

By Email: contracts@smig-inc.com

By Fax: 314-685-8013

By Mail: Senior Marketing Insurance Group
 415 S 18th St, Suite 101
 Saint Louis, MO, 63103

The licensing process cannot begin until all of the above items have been received!!! If you have any questions, please call us at: 1-866-345-0109.



CONSUMER REPORT AUTHORIZATION FORM

CONSENT TO OBTAIN CONSUMER REPORTS

This notice is being provided to you by Americo Financial Life and Annuity Insurance Company ("Company") pursuant to the Fair Credit Reporting Act ("FCRA"). As used herein, "the Company" means the above-identified insurer as well as its parents, subsidiaries, affiliates, officers, employees, agents and representatives.

In connection with determining your eligibility to be appointed or sponsored as an agent of the Company, and to maintain such appointment, in one or more states, the Company will from time to time conduct background checks. Such background checks may include the ordering of "consumer reports" from a "consumer reporting agency" containing information on, among other items, your criminal and credit history. These terms are defined in the FCRA. Additional information concerning the FCRA, 15 U.S.C. § 1661 et seq., is available at the Federal Trade Commission's website (<http://www.ftc.gov>).

I hereby authorize the Company and its authorized agents to obtain consumer reports and/or investigative consumer reports in accordance with the FCRA. I further authorize any present or former employers, consumer reporting agencies, educational institutions, criminal justice agencies, departments of motor vehicles, public agencies, financial institutions, or other persons or agencies having knowledge of me to submit information, including data received from other sources, in order that my qualifications may be evaluated.

I understand that this release is valid for any future consumer report that may be requested by the Company. I hereby consent to the Company obtaining such information from time to time, as the Company, in its sole discretion, deems necessary. I further consent to the disclosure of the information to government or regulatory agencies. I also continually authorize the Company to disclose any information received as a result of its background check to my Agency or Independent Marketing Organization.

I understand and agree that the information obtained about me may be used and relied upon by the Company in assessing and evaluating my application for appointment. I hereby release the Company, its authorized agents and any person or entity which provides information pursuant to this authorization, from any and all liabilities, claims or lawsuits relating to the information obtained from any and all of the above-referenced sources, or from furnishing the same.

I acknowledge that a copy of this release may be relied upon in lieu of and shall have the same force and effect as the original. This release is valid for all federal, state, county and local agencies and authorities.

Applicant's Signature (Required)

Date (Required)

Applicant's Name (Printed)



AGENT/AGENCY APPLICATION

Applicant is: An Individual Corporation LLC Partnership

Individual Information (All applicants must complete)

52675 (11/14)

Full Legal Name			
<input type="checkbox"/> Mr.	First Name	Middle Name	Last Name
<input type="checkbox"/> Ms.			
Date of Birth(MM/DD/YYYY)	Social Security Number	Business E-Mail Address	
Business Phone	Business Fax	Cell Phone	
Residence Address			
Street	City	State	Zip Code
Mailing Address			
Street	City	State	Zip Code

Business Entity Information (Corporation, LLC, or Partnership)

Name and Mailing Address			
Business Name	Tax ID		
Street	City	State	Zip Code
Name and Title of Each Principal/Owner Including Applicant (Required for Entities)			
If additional space is required, please attach a separate sheet			
Name	Title		
Name	Title		
Name	Title		
Name:	Title		

Beneficiary Designation

If you are married and reside in a community property state and name someone other than your spouse as beneficiary, payment of commissions may be delayed or disputed unless your spouse provides written authorization consenting to the beneficiary designation.

Name	Date of Birth (MM/DD/YYYY)	Social Security Number
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INDIVIDUAL BACKGROUND QUESTIONS

BACKGROUND: Violent Crime Control and Law Enforcement Act of 1994: The Violent Crime Control and Law Enforcement Act of 1994 is the largest crime bill in the history of the United States. For purposes of this application, the Crime Act of 1994 prohibits any individual who has been convicted of a criminal felony involving dishonesty or breach of trust to willfully engage in business of insurance. Acts that would exclude you from engaging in the business of insurance include, but are not necessarily limited to, (1) knowingly make false material statements in financial reports submitted to insurance regulators; (2) embezzle or misappropriate monies or funds of an insurance company; (3) make material false entries in the records of an insurance company in an effort to deceive officials of the company or regulators regarding the financial condition of the company; (4) obstruct an investigation by an insurance regulator. In addition to the foregoing, THE 1994 CRIME ACT MAKES IT A FEDERAL CRIME FOR INDIVIDUALS WHO HAVE BEEN CONVICTED OF A FELONY INVOLVING DISHONESTY, BREACH OF TRUST, OR ANY OF THE OFFENSES LISTED ABOVE TO WILLFULLY ENGAGE IN THE BUSINESS OF INSURANCE. Willfully engaging in the business of insurance includes acting as an insurance agent. Penalties for violating the 1994 Crime Act include civil fines up to \$50,000 and imprisonment up to 15 years. IT IS YOUR RESPONSIBILITY TO KNOW IF YOU HAVE A CRIMINAL CONVICTION THAT PLACES YOU IN VIOLATION OF THE 1994 CRIME ACT, AND TO REPORT SUCH CONVICTIONS TO AMERICO.

- 1.) Will you be in violation of the 1994 Crime Act if you act as an insurance agent?
2.) Did you file a 1033 form in any state due to felony charges covered by 18USC 1033?
If so, did you gain consent to write?
3.) Have you ever filed bankruptcy?

If you are applying as an Entity skip the below questions and move to page 3

- 4.) Are you currently charged with or have you ever been convicted of a crime, including felony, misdemeanor, or military offense?
5.) Do you have any outstanding debt(s) with any insurance company (ies)?
6.) Do you currently have a state, federal or any taxing authority tax lien?
7.) Do you have any outstanding civil judgments?
8.) Have you ever been refused a bond or had a bond cancelled?
9.) Have you ever been named or involved as a party in an administrative proceeding including but not limited to FINRA sanctions or arbitration proceeding regarding any professional or occupational license or registrations?

If you answered "Yes" to any questions, please attach a signed written explanation with all relevant information and supporting documents (e.g. Official Court Records, Repayment Agreements and corresponding receipts).

To aid in expediting your application, please provide the following additional documentation for "yes" responses to the below questions. Failure to provide a signed explanation and supporting documentation will delay contracting.

- Questions 1 and 2: Along with the written explanation, you must attach a copy of the 1033 consent from your home state.
Question 3: If satisfied, disposed of or discharged, provide court documentation and/or 6 months repayment history
Question 5: Provide 6 months proof of repayment.
Question 6: Provide 6 months proof of repayment from taxing authority
Question 9: Attach:

- a) a written statement identifying the type of license, all parties involved (including their percentage of ownership, if any) and explaining the circumstances of each incident.
b) a copy of the Notice of Hearing or other document that states the charges and allegations, and
c) a copy of the official document which demonstrates the resolution of the charges or any final judgments

BUSINESS ENTITY BACKGROUND QUESTIONS

(Required for all Entities)

BACKGROUND: Violent Crime Control and Law Enforcement Act of 1994: The Violent Crime Control and Law Enforcement Act of 1994 is the largest crime bill in the history of the United States. For purposes of this application, the Crime Act of 1994 prohibits any individual who has been convicted of a criminal felony involving dishonesty or breach of trust to willfully engage in business of insurance. Acts that would exclude you from engaging in the business of insurance include, but are not necessarily limited to, (1) knowingly make false material statements in financial reports submitted to insurance regulators; (2) embezzle or misappropriate monies or funds of an insurance company; (3) make material false entries in the records of an insurance company in an effort to deceive officials of the company or regulators regarding the financial condition of the company; (4) obstruct an investigation by an insurance regulator. In addition to the foregoing, **THE 1994 CRIME ACT MAKES IT A FEDERAL CRIME FOR INDIVIDUALS WHO HAVE BEEN CONVICTED OF A FELONY INVOLVING DISHONESTY, BREACH OF TRUST, OR ANY OF THE OFFENSES LISTED ABOVE TO WILLFULLY ENGAGE IN THE BUSINESS OF INSURANCE.** Willfully engaging in the business of insurance includes acting as an insurance agent. Penalties for violating the 1994 Crime Act include civil fines up to \$50,000 and imprisonment up to 15 years. **IT IS YOUR RESPONSIBILITY TO KNOW IF YOU HAVE A CRIMINAL CONVICTION THAT PLACES YOU IN VIOLATION OF THE 1994 CRIME ACT, AND TO REPORT SUCH CONVICTIONS TO AMERICO.**

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1.) Is the Business Entity or any Owner, Partner, Officer or Director of the Business Entity, or Member or Manager of a Limited Liability Company currently being charged with or has ever been convicted of a crime, including felony, misdemeanor, or military offense? <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>Convicted includes a guilty verdict, withdrawn plea, probation, nolo contendere plea, suspended sentences, or fines. You may exclude traffic citations and juvenile offenses.</i> | | |
| 2.) Does the Business Entity or any Owner, Partner, Officer or Director of the Business Entity, or Member or Manager of a Limited Liability Company have any outstanding debt(s) with any insurance company (ies)? <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If "Yes", please provide: Name: _____ Amount: _____ Relationship: _____ | | |
| 3.) Has the Business Entity or any Owner, Partner, Officer or Director of the Business Entity, or Member or Manager of a Limited Liability Company, ever been subject to a bankruptcy proceeding? (Do not include personal bankruptcies, unless they involve funds held on behalf of others.) <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.) Does the Business Entity or any Owner, Partner, Officer or Director of the Business Entity, or Member or Manager of a Limited Liability Company currently have a state, federal or any taxing authority tax lien? <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5.) Does the Business Entity or any Owner, Partner, Officer or Director of the Business Entity, or Member or Manager of a Limited Liability Company have any outstanding civil judgments? <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6.) Has the Business Entity or any Owner, Partner, Officer or Director of the Business Entity, or Member or Manager of a Limited Liability Company ever been refused a bond or had a bond cancelled (other than for non-payment)?..... <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7.) Has the Business Entity or any Owner, Partner, Officer or Director of the Business Entity, or Member or Manager of a Limited Liability Company ever been named or involved as a party in an administrative proceeding including but not limited to FINRA sanctions or arbitration proceeding regarding any professional or occupational license, or registrations? Includes State Insurance Department investigations, license suspensions, revocations, or administrative fines. <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>"Involved" means having a license censured, suspended, revoked, canceled, terminated; or, being assessed a fine, a cease and desist order, a prohibition order, a compliance order, placed on probation, sanctioned or surrendering a license to resolve administrative action. "Involved" also means being named as a party to an administrative or arbitration proceeding, which is related to a professional or occupational license or registration. "Involved" also means having a license application denied or the act of withdrawing an application to avoid a denial. You may EXCLUDE terminations due solely to noncompliance with continuing education requirements or failure to pay a renewal fee.</i> | | |

If you answered "yes" to any questions, please attach a signed written explanation with all relevant information and supporting documents (e.g. Official Court Records, Repayment Agreements and corresponding receipts).

To aid in expediting your application, please provide the following additional documentation for "yes" responses to the below questions.

Failure to provide a signed explanation and supporting documentation will delay contracting.

Question 2: Provide 6 month's proof of repayment.

Question 3: If satisfied, disposed of or discharged, provide court documentation and/or 6 months repayment history

Question 4: Provide 6 months proof of repayment from taxing authority

Question 7: Attach:

- a) a written statement identifying the type of license, all parties involved (including their percentage of ownership, if any) and explaining the circumstances of each incident.
- b) a copy of the Notice of Hearing or other document that states the charges and allegations, and a copy of the official document which demonstrates the resolution of the charges or any final judgments.

LICENSES

Non-resident appointment fees will be deducted directly from your commissions upon our acceptance of the contract or once the first piece of business has been submitted, depending on the state's appointment regulations.

I plan to write business in the following states and would like to be appointed in accordance with the states requirements.

- | | | | | |
|---|--|---|---|--|
| <input type="checkbox"/> Alabama | <input type="checkbox"/> Hawaii | <input type="checkbox"/> Michigan | <input type="checkbox"/> North Dakota | <input type="checkbox"/> Virginia |
| <input type="checkbox"/> Alaska | <input type="checkbox"/> Idaho | <input type="checkbox"/> Minnesota | <input type="checkbox"/> Ohio | <input type="checkbox"/> Washington |
| <input type="checkbox"/> Arizona | <input type="checkbox"/> Illinois | <input type="checkbox"/> Mississippi | <input type="checkbox"/> Oklahoma | <input type="checkbox"/> West Virginia |
| <input type="checkbox"/> Arkansas | <input type="checkbox"/> Indiana | <input type="checkbox"/> Missouri | <input type="checkbox"/> Oregon | <input type="checkbox"/> Wisconsin |
| <input type="checkbox"/> California | <input type="checkbox"/> Iowa | <input type="checkbox"/> Montana | <input type="checkbox"/> Pennsylvania | <input type="checkbox"/> Wyoming |
| <input type="checkbox"/> Colorado | <input type="checkbox"/> Kansas | <input type="checkbox"/> Nebraska | <input type="checkbox"/> Rhode Island | |
| <input type="checkbox"/> Connecticut | <input type="checkbox"/> Kentucky | <input type="checkbox"/> Nevada | <input type="checkbox"/> South Carolina | |
| <input type="checkbox"/> Delaware | <input type="checkbox"/> Louisiana | <input type="checkbox"/> New Hampshire | <input type="checkbox"/> South Dakota | |
| <input type="checkbox"/> District of Columbia | <input type="checkbox"/> Maine | <input type="checkbox"/> New Jersey | <input type="checkbox"/> Tennessee | |
| <input type="checkbox"/> Florida | <input type="checkbox"/> Maryland | <input type="checkbox"/> New Mexico | <input type="checkbox"/> Texas | |
| <input type="checkbox"/> Georgia | <input type="checkbox"/> Massachusetts | <input type="checkbox"/> North Carolina | <input type="checkbox"/> Utah | |

If you hold a non-resident license in Florida and plan to physically solicit in any Florida county, you must indicate those counties below, as an appointment is required. Americo will pay the fee for the county appointment.

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Alachua County | <input type="checkbox"/> Franklin County | <input type="checkbox"/> Lee County | <input type="checkbox"/> Pinellas County |
| <input type="checkbox"/> Baker County | <input type="checkbox"/> Gadsden County | <input type="checkbox"/> Leon County | <input type="checkbox"/> Polk County |
| <input type="checkbox"/> Bay County | <input type="checkbox"/> Gilchrist County | <input type="checkbox"/> Levy County | <input type="checkbox"/> Putnam County |
| <input type="checkbox"/> Bradford County | <input type="checkbox"/> Glades County | <input type="checkbox"/> Liberty County | <input type="checkbox"/> Santa Rosa County |
| <input type="checkbox"/> Brevard County | <input type="checkbox"/> Gulf County | <input type="checkbox"/> Madison County | <input type="checkbox"/> Sarasota County |
| <input type="checkbox"/> Broward County | <input type="checkbox"/> Hamilton County | <input type="checkbox"/> Manatee County | <input type="checkbox"/> Seminole County |
| <input type="checkbox"/> Calhoun County | <input type="checkbox"/> Hardee County | <input type="checkbox"/> Marion County | <input type="checkbox"/> St. Johns County |
| <input type="checkbox"/> Charlotte County | <input type="checkbox"/> Hendry County | <input type="checkbox"/> Martin County | <input type="checkbox"/> St. Lucie County |
| <input type="checkbox"/> Citrus County | <input type="checkbox"/> Hernando County | <input type="checkbox"/> Miami-Dade County | <input type="checkbox"/> Sumter County |
| <input type="checkbox"/> Clay County | <input type="checkbox"/> Highlands County | <input type="checkbox"/> Monroe County | <input type="checkbox"/> Suwannee County |
| <input type="checkbox"/> Collier County | <input type="checkbox"/> Hillsborough County | <input type="checkbox"/> Nassau County | <input type="checkbox"/> Taylor County |
| <input type="checkbox"/> Columbia County | <input type="checkbox"/> Holmes County | <input type="checkbox"/> Okaloosa County | <input type="checkbox"/> Union County |
| <input type="checkbox"/> DeSoto County | <input type="checkbox"/> Indian River County | <input type="checkbox"/> Okeechobee County | <input type="checkbox"/> Volusia County |
| <input type="checkbox"/> Dixie County | <input type="checkbox"/> Jackson County | <input type="checkbox"/> Orange County | <input type="checkbox"/> Wakulla County |
| <input type="checkbox"/> Duval County | <input type="checkbox"/> Jefferson County | <input type="checkbox"/> Osceola County | <input type="checkbox"/> Walton County |
| <input type="checkbox"/> Escambia County | <input type="checkbox"/> Lafayette County | <input type="checkbox"/> Palm Beach County | <input type="checkbox"/> Washington County |
| <input type="checkbox"/> Flagler County | <input type="checkbox"/> Lake County | <input type="checkbox"/> Pasco County | |

AUTHORIZATION FOR ELECTRONIC FUNDS TRANSFER (DIRECT DEPOSIT)

Commissions are sent daily (default), weekly, or monthly through Electronic Funds Transfer into your bank account.

I hereby authorize the Company to pay my commissions by depositing my commissions through Electronic Funds Transfer and to initiate, if necessary, adjustments involving errors to the deposits, but only to the extent of the errors, in the account indicated below. The undersigned also authorizes the depository named below, (the "Depository") to accept such deposits and make any requested adjustments to such account as instructed by the Company. It is agreed that these deposits may be made electronically and under the Rules of the Mid-America Automated Clearing House Association. This authority is to remain in full force and effect until the Company has received written notification from me of its termination, allowing the Company enough time to act on it.

Please complete all information.

Account Holder's Name (please print)

Applicant's preferred pay frequency: Daily Weekly Monthly

Routing Number

Account Number

Please include one of the following:

Voided check for checking account (or)

Deposit slip for savings account (or)

- must indicate account number
- note that routing number on the deposit slip is not the bank routing number needed to transmit a deposit, please confirm routing number with your bank and write above
- verify that the numbers are the same as on your account as these sometimes differ

Bank routing and account numbers on financial institutions letterhead

Tape voided check or deposit slip here.

REPRESENTATIONS AND AGREEMENTS

- I can solicit business only in states where I am licensed.
- I will not solicit business in states that prohibit solicitation prior to my appointment.
- As a general rule, it is not acceptable for me to make a solicitation anywhere other than in the resident state of the applicant.
- Premium checks will be payable to and sent directly to the Company. No premium checks will be deposited to a personal or business account. Money orders will not be accepted for initial premium.
- I will represent all policies according to their applicable provisions, including any illustration of values and benefits. Full disclosure will be made regarding all policy features and conditions relevant to the receipt of benefits.
- I will abide by all rules and regulations of the Company, which may be subject to change at any time.
- I understand that I must complete Anti-Money Laundering Training on the LIMRA web site and I also understand that Amerigo requires me to renew my certification every 2 years. Policies falling under the Anti-Money Laundering Training requirements will not be issued unless the initial and renewal training requirements have been fully met.
- If I am convicted of or plead guilty to any felony involving dishonesty or breach of trust, or any offense under Title 18 U.S. Code Sec. 1033, or am required to file under any sex offender registration law of any state, I will immediately report it to the Company.

TAXPAYER IDENTIFICATION CERTIFICATION

1. Under penalties of perjury, I certify that I am a US citizen or other US person, and that the number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me).
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.*
3. I am exempt from FATCA (Foreign Account Tax Compliance Act) reporting.

*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 failed to report all interest or dividends on your tax return.

“The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.”

E&O COVERAGE

By signing this application, you acknowledge that you are responsible for maintaining, and agree to maintain, E&O liability coverage of not less than \$1 million at the time any business is written on behalf of the company, during the term of this Agent Agreement and for a period of two years after the Agreement is terminated. Your certificate must indicate coverage for any line of business you sell. (i.e. Life, annuity)

Carrier Name	Coverage Amount (min. \$1 million)	Policy Number	Expiration Date

AGENT'S DECLARATION AND AUTHORIZATION

- It is understood that I will be responsible for any and all commission chargebacks to my account and to the accounts of any other agents on whose production I receive a commission override. Should litigation be necessary to collect any debit balance, reasonable attorney fees and collection costs plus interest at the highest rate allowable by state law may also be awarded to the Company.
- I am fully aware and understand that as a licensed insurance agent it is my responsibility to completely understand the products and companies I represent and to properly solicit these products to consumers in accordance with insurance solicitation laws and consumer protection laws within the state(s) where I hold a resident and/or non-resident license.

I hereby certify that I have truthfully answered the questions above. I further certify that in answering the questions above I have exercised due diligence in researching all answers provided, including, but not limited to, examining whether I have any criminal convictions that place me on violation of the 1994 Crimes Act. The information is to the best of my knowledge and belief accurate Statements of Fact. I further understand that if any material information given in this application is found to be incorrect or incomplete, it will be grounds for termination at the Company's discretion, and grounds for any state, federal, contractual or other remedies the Company may have available to it. I understand and agree to the terms of that document known as the Agent Agreement with Amerigo Life, Inc. Affiliates, (form No. SMC-010100), which is incorporated into and made a part hereof by this reference, and agree that all obligations imposed thereunder shall survive the termination of such Agent Agreement. If you are signing on behalf of a General Agency or Independent Marketing Organization, by signing this Agent Agreement, you agree that you are a duly authorized principal for your General Agency or Independent Marketing Organization, and that you have authority to sign and bind your General Agency or Independent Marketing Organization to the terms set forth herein, and that your signature authorizes the disclosure of the requested information.

Applicant's Signature (Required)

Date (Required)

Applicant's Name (Printed)

BUSINESS ASSOCIATE AGREEMENT

15-106-1 (05/15)

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and regulations issued thereunder (the "Privacy Rule" and the "Security Rule"), impose certain privacy protection and security requirements upon Amerigo Life, Inc. and/or its insurance subsidiaries (the "Covered Entity"). One of those requirements is that the Covered Entity ensure that its contracts with its "business associates," including You (the "Business Associate"), impose certain obligations upon the Business Associate with respect to maintaining the confidentiality of protected health information ("PHI"), and the security of electronic protected health information ("E-PHI"), in the possession of the Business Associate and relating to services provided by Business Associate to the Covered Entity. The purpose of this Agreement is to articulate the duties and responsibilities of Business Associate under the Final HIPAA Omnibus Rule, which includes modifications to the HIPAA Privacy and Security Rules as mandated by the Health Information Technology for Economic and Clinical Health ("HITECH") Act, and also includes modifications to the Breach Notification Rule (collectively, the "HIPAA Rules").

SECTION I: EFFECTIVE DATE

The provisions of this Agreement shall be effective on the date signed by Business Associate.

SECTION II: DEFINITIONS

- (A) **Breach.** "Breach" means the acquisition, access, use, or disclosure of PHI in a manner not permitted by the Privacy Rule where such action compromises the security or privacy of the PHI. A Breach does not include the following:
- (1) A use or disclosure of PHI that does not include the identifiers listed at 45 C.F.R. § 164.514(e)(2), date of birth, and zip code;
 - (2) Any unintentional acquisition, access, or use of PHI by Business Associate, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted by this Agreement;
 - (3) Any inadvertent disclosure by a person who is authorized to access PHI as the Business Associate to another person authorized to access PHI and does not result in further use or disclosure in a manner not permitted by this Agreement; or
 - (4) A disclosure of PHI where Business Associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

Except as provided above, an acquisition, access, use, or disclosure of Protected Health Information in a manner not permitted by the Privacy Rule is presumed to be a Breach unless the Business Associate demonstrates that there is a low probability that the Protected Health Information has been compromised based on a risk assessment of at least the following factors:

- (1) The nature and extent of the Protected Health Information involved, including the types of identifiers and the likelihood of re-identification;
 - (2) The unauthorized person who used the Protected Health Information or to whom the disclosure was made;
 - (3) Whether the Protected Health Information was actually acquired or viewed; and
 - (4) The extent to which the risk to the Protected Health Information has been mitigated.
- (B) **Breach Notification Rule.** "Breach Notification Rule" shall mean the Standards and Implementation Specifications for Notification of Breaches of Unsecured Protected Health Information under 45 CFR Parts 160 and 164, Subparts A and D.
- (C) **Business Associate.** "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this Agreement, shall mean You, the person/entity entering into this Agreement as Business Associate.
- (D) **Covered Entity.** "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this Agreement, shall mean Amerigo Life, Inc. and/or its insurance subsidiaries.
- (E) **Designated Record Set.** "Designated Record Set" shall have the same meaning as the term "designated record set" in 45 CFR 164.501.
- (F) **Electronic Protected Health Information.** "Electronic Protected Health Information" shall have the same meaning as the term "electronic protected health information" in 45 CFR 160.103, limited to the electronic information created or received by Business Associate from or on behalf of the Covered Entity.
- (G) **HIPAA Rules.** "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.
- (H) **Individual.** "Individual" shall have the same meaning as the term "individual" in 45 CFR 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g).
- (I) **Law Enforcement Delay.** "Law Enforcement Delay" means when a law enforcement official notifies Business Associate that a notice, notification, or posting relating to the Breach would impede a criminal investigation or cause damage to national security.
- (J) **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.
- (K) **Protected Health Information.** "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR 160.103, limited to the information created or received by Business Associate from or on behalf of the Covered Entity.

- (1) Provide an opportunity for Business Associate to cure the breach or end the violation, or terminate this Agreement and any underlying services provided by Business Associate if Business Associate does not cure the breach or end the violation within the time specified by the Covered Entity;
 - (2) Immediately terminate this Agreement and any underlying services provided by Business Associate if Business Associate has breached a material term of this Agreement and cure is not possible; or
 - (3) If neither termination nor cure are feasible, the Covered Entity shall report the violation to the Secretary.
- (C) Effect of Termination.
- (1) Except as provided in paragraph (2) below, upon termination of this Agreement for any reason, Business Associate shall return or destroy all Protected Health Information received from the Covered Entity, or created, received, maintained, or transmitted by Business Associate on behalf of the 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 the Covered Entity notification of the conditions that make return or destruction infeasible. Upon the Covered Entity's agreement 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.

SECTION VIII: MISCELLANEOUS

- (A) Regulatory References. A reference in this Agreement to a section in the HIPAA Rules 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 the Covered Entity to comply with the requirements of the HIPAA Rules.
- (C) Survival. The respective rights and obligations of Business Associate under the Term and Termination Section of this Agreement shall survive the termination of this Agreement.
- (D) Interpretation. Any ambiguity in this Agreement shall be resolved to permit the Covered Entity to comply with the HIPAA Rules.
- (E) Notices. All notices and other communications required or permitted under this Agreement shall be in writing and shall be sent as set forth below:

If to the Covered Entity:	If to Business Associate:
Americo Life, Inc. 301 West 11 th Street Kansas City, MO 64105	Current Contact Information on File with Covered Entity
- (F) Benefit and Assignment. This Agreement shall be binding upon and shall inure to the benefit of the parties hereto and their respective successors and assigns as permitted hereunder. There are no third party beneficiaries to this Agreement. No party to this Agreement may assign this Agreement or any rights hereunder without the prior written consent of the parties hereto.
- (G) Captions. The captions of sections of this Agreement are for convenience only and shall not control or affect the meaning or construction of any of the provisions of this Agreement.
- (H) Severability. The provisions of this Agreement shall be severable, and if any provision of this Agreement is held illegal, invalid, or unenforceable, the remainder of this Agreement shall continue in full force and effect.
- (I) Entire Agreement. This Agreement constitutes the entire agreement among the parties with regard to the subject matter of this Agreement.

IN WITNESS WHEREOF, I understand and agree to the terms of this document known as the Business Associate Agreement with Americo Life, Inc., which is incorporated into and made a part of my Agent Agreement hereof by this reference, and agree that all obligations imposed thereunder shall survive the termination of such Agreement. If you are signing on behalf of a General Agency or Independent Marketing Organization, by signing this Agent Agreement, you agree that you are a duly authorized principal for your General Agency or Independent Marketing Organization, and that you have authority to sign and bind your General Agency or Independent Marketing Organization to the terms set forth herein, and that your signature authorizes the disclosure of any requested information.

Applicant's Signature (Required)

Date (Required)

Applicant's Name (Printed)

Americo Agent Number (if applicable)

Americo

Commission Advance Options

Life Advance

	3 months
	6 months
	9 months

FE Advance

	3 months
	6 months
	9 months

MedSupp Advance

	3 months
	6 months
	9 months
	12 months

Override

Commission Agreement 03-107-4 (06/15)



I wish to collect override commissions in those state(s) where insurance laws or regulations allow such commissions to be paid to individuals who do not participate in the sale of insurance policies. I request that the Licensing and Contracting Department at Americo Financial Life and Annuity Insurance Company (Americo) initiate the necessary recordkeeping to provide such commission payments to me in the following states:

As of February 9, 2006, the states that allow overrides to be paid without a producer holding an active license or appointment in the state are listed below. I have checked those states in which I intend to collect overrides:

- | | | | | | |
|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|
| <input type="checkbox"/> AK | <input type="checkbox"/> DC | <input type="checkbox"/> IN | <input type="checkbox"/> MN | <input type="checkbox"/> NV | <input type="checkbox"/> TN |
| <input type="checkbox"/> AR | <input type="checkbox"/> DE | <input type="checkbox"/> KS | <input type="checkbox"/> MO | <input type="checkbox"/> OH | <input type="checkbox"/> TX |
| <input type="checkbox"/> AZ | <input type="checkbox"/> HI | <input type="checkbox"/> LA | <input type="checkbox"/> NC | <input type="checkbox"/> OK | <input type="checkbox"/> WA |
| <input type="checkbox"/> CA | <input type="checkbox"/> IA | <input type="checkbox"/> MD | <input type="checkbox"/> NE | <input type="checkbox"/> OR | <input type="checkbox"/> WY |
| <input type="checkbox"/> CO | <input type="checkbox"/> ID | <input type="checkbox"/> ME | <input type="checkbox"/> NH | <input type="checkbox"/> RI | |
| <input type="checkbox"/> CT | <input type="checkbox"/> IL | <input type="checkbox"/> MI | <input type="checkbox"/> NJ | <input type="checkbox"/> SC | |

In order to collect these override commissions I agree to be bound by the following terms of this agreement:

1. I will not sell, solicit, or negotiate insurance business in the above-named states.
2. I will not be connected to the actual sale of any insurance policy in the above named states.
3. I will be responsible for notifying Americo staff thirty days in advance of a change in my circumstances whereby I plan to obtain a producer's license in any of the above named states.
4. I will provide Americo staff a copy of the actual producer's license I obtain in any of the above named states prior to soliciting any business in any such state.
5. I understand that a failure to notify Americo of a change in my licensing status in any of the above-mentioned states could result in fines or administrative actions from the Department (s) of Insurance in the respective states.
6. I agree to indemnify Americo should such fines or administrative actions be taken which result in Americo incurring legal fees or other damages.

Agent Name and Agent Code

Date

Agent Name Signature