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
415 S. 18th Street, 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:
866-345-0109.

MEDICO®

Medico Insurance Company
Medico Corp Life Insurance Company
Corporate Offices – Omaha, NE

Medico Insurance Company
Administrative Services – PO Box 10386
Des Moines, IA 50306

Medico Corp Life Insurance Company
Administrative Services – PO Box 10482
Des Moines, IA 50306

www.GoMedico.com *Toll-Free 1-800-547-2401, Option 3* *Fax 515-247-2435*

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 ("Medico") and/or Medico Corp Life Insurance Company ("Medico Corp") information within their records concerning me. If accepted, I will comply with all regulations of this State and Medico and/or Medico Corp 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 Medico and/or Medico Corp will be available to me upon my written request.

Applicant Signature _____ SIGN HERE **Date** _____

This applicant is recommended for appointment as a Distributor assigned to my jurisdiction, subject to the terms of my contract with Medico and/or Medico Corp. 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 _____ **Date** _____

MEDICO®

Medico Insurance Company
Medico Corp Life Insurance Company
Corporate Offices – Omaha, NE

Medico Insurance Company
Administrative Services – PO Box 10386
Des Moines, IA 50306

Medico Corp Life Insurance Company
Administrative Services – PO Box 10482
Des Moines, IA 50306

www.GoMedico.com *Toll-Free 1-800-547-2401, Option 3* *Fax 515-247-2435*

Distributor Direct Deposit Authorization

Instructions
Please complete Parts A through C, attach a voided check, and return to Medico Insurance Company ("Medico") and/or Medico Corp Insurance Company ("Medico Corp"). For your convenience you may also fax in the form and voided check to 515-247-2435.

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 and/or Medico Corp 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_____ SIGN HERE Date_____
If joint account.

Printed Name_____

Designated Record Set means (a) a group of records maintained by or for Company that is 1) medical records and billing records about individuals maintained by or for a covered health care provider; 2) enrollment, payment, claims adjudication and case or medical management record systems maintained by or for a covered health plan or 3) used in whole or in part by or for the covered entity to make decisions about individuals.

Disclose/Disclosure means the release, transfer, and provision of access to or divulging in any other manner of information outside the entity holding the information.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, otherwise known as Public Law 104-191. HIPAA regulations were designed, in part, to improve the efficiency and effectiveness of the healthcare system by standardizing the interchange of electronic data for specified administrative and financial transactions and to protect the security and confidentiality of Protected Health Information

Individual means the person who is the subject of protected health information and shall include a person who qualifies as a personal representative in accordance with the Privacy Regulation.

Privacy Rule means the Standards for Privacy of Individually Identifiable Health Information at CFR part 160 and part 164, subparts A and E.

Protected Health Information ("PHI") means individually identifiable information, including demographic information, that (i) 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; (ii) identifies the individual or for which there is a reasonable basis for believing that the information can be used to identify the individual; and (iii) is received by Business Associate from or on behalf of Company, or is created by Business Associate for or on behalf of Company, or is made accessible to Business Associate by Company. It does not include educational records covered by the Family Educational Right and Privacy Act and employment records held by Company in our role as employer.

Secretary means the Secretary of the Department of Health and Human Services or his or her designee.

Security Rule means the Standards for security of individual's electronic personal health information that is created, received, used, or maintained by a covered entity and is located at 45 CFR Part 160 and Subparts A and C of Part 164

Personally Identifiable Financial Information ("PIFI"): Any information, whether oral or recorded in any form or medium, about an Individual that relates to an insurance product, a transaction involving an insurance product or service, or providing an insurance product or service; or any list, description or other grouping of consumers (and publicly available information pertaining to them) that is derived using any personally identifiable information that is not publicly available (See "non-public personal information" as defined in the Gramm-Leach-Bliley Act Title V, Section 509).

Use with respect to PHI means the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

IN WITNESS WHEREOF, the parties have executed this Agreement effective as of the date stated.

BUSINESS ASSOCIATE:

Date:_____

Signature:_____ SIGN HERE

Printed Name: _____

Title:_____

Individual, Partnership or Corporation Name:

_____

MEDICO INSURANCE COMPANY

President

MEDICO CORP LIFE INSURANCE COMPANY

President

C. In the event any provision of this Agreement is found to be invalid or unenforceable, the remaining provisions shall remain in effect.

D. This Agreement and attachments referenced herein, including but not limited to addendums, Commission Schedules, and Company policies and procedures, constitute the entire contract between the parties and supersede any and all previous agreements between the parties; provided, however, Distributor's right to commissions from policies written pursuant to a previous agreement between the parties shall not be modified.

E. Company may modify this Agreement, including but not limited to the Commission Schedules, upon thirty (30) days prior written notice to Distributor, but any such modification shall not reduce the rate or rates with respect to commission payments due Distributor in connection with policies produced by Distributor and issued by Company with effective dates prior to the effective date of such modification. Notwithstanding the foregoing, upon the enactment of any law or regulation, or any order or direction of any governmental agency affecting this Agreement, Company may, by written notice to Distributor, amend the Agreement in such manner as Company determines necessary to comply with such law or regulation, or any order or directive of any governmental agency.

21. This Agreement is effective _____, 20____.

Distributor and Company have entered into this Agreement through their duly authorized representatives on the dates set forth below.

DISTRIBUTOR

Agency Name, if applicable_____
(Please Print)

By:_____ SIGN HERE _____
(Signature) (Date)

Printed Name:_____

Title:_____
(If applicable)

Acknowledged By:

_____

_____

Accepted:

MEDICO® INSURANCE COMPANY

By_____
William P. Jetter, Vice President of Sales

MEDICO® CORP LIFE INSURANCE COMPANY

By_____
William P. Jetter, Vice President of Sales

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”.

SIGN HERE

_____

Signature

MEDICO®
INSURANCE COMPANY
Corporate Office - Omaha, Nebraska
Administrative Services - P.O.Box 10386, Des Moines, Iowa 50306-0386
Customer Service • 1-800-228-6080

ADVANCE COMMISSION ADDENDUM

This Advance Commission Addendum ("Addendum") is an Addendum to the Distributor Agreement ("Agreement") you ("Distributor") have already signed with Medico® Insurance Company ("Medico") and establishes the terms and conditions pursuant to which Medico will advance commissions to you. Commissions, including advances, are payable pursuant to the Commission Schedule. Distributor represents and warrants that any advances are solely for business purposes.

It is understood and agreed:

1. Medico will pay commission advances weekly on eligible policies that are issued and whose premiums are paid on monthly bank draft or credit card mode. The advance commission will equal nine (9) months of the annualized commission. Medico reserves the right, in its sole discretion and without prior notice, to add or remove products available for advance commissions.
2. In the event of any refund, rescission, lapsed, stop-payment or cancelled policy, any unearned portion of the advance will be deducted from the next payment otherwise payable to Distributor, including but not limited to advance(s) and any earned first-year and renewal commission.
3. Distributor will be indebted to Medico by receiving advance commission under this Addendum. Any indebtedness will be legal debt that will be due on demand. Medico will retain a first lien on all sums due for the satisfaction of the debt and is not limited to this means of collection. The advance debit balance shall accrue interest at a rate of 1% per month (12.7 APR).
4. Medico may amend or terminate this Addendum at any time with prior written notice to Distributor, which notice shall not be required to meet the requirements under Section 24 of the Agreement.
5. This Addendum shall be read together and construed as one document with the Agreement, but to the extent of any inconsistency or ambiguity, this Addendum shall govern. Except as specifically provided in this Addendum, all of the terms and conditions of the Distributor Agreement shall remain in full force and effect.
6. If this Addendum and/or Agreement are terminated for any reason, Medico may retain all first year and renewal commissions to offset advance amounts outstanding. The security created hereunder and Distributor's obligation to repay any indebtedness shall survive termination of this Addendum and/or the Agreement.
7. If commission advances are not repaid by the Distributor when due pursuant to the terms hereof, Distributor agrees to pay all costs of collection, including, but not limited to, attorney fees, costs of suit, collection fees or such other costs and expenses as may be incurred by Medico in such suit or action. This section shall survive termination of this Addendum and/or the Agreement.

Accepted, agreed and signed by the parties:

DISTRIBUTOR

_____	_____	_____
Signature of Distributor	Name of Distributor (*please print or type*)	Date

GUARANTOR - I recommend this Distributor and request that Medico approve this Distributor's advance commissions. I agree to accept responsibility as a Guarantor and to be held liable for all debts created hereunder by the above Distributor as provided in the Agreement. All terms of this Addendum shall apply to me.

_____	_____	_____
Signature of Guarantor	Name of Guarantor (*please print or type*)	Date
_____	_____	
Title	Guarantor's Distributor Number	

For Home Office Use Only:

Accepted: Medico Insurance Company

By: _____	_____	_____
Company Representative	Title	Date

MEDICO®

Medico Insurance Company
Medico Corp Life Insurance Company
Corporate Offices – Omaha, NE

Medico Insurance Company
Administrative Services – PO Box 10386
Des Moines, IA 50306

Medico Corp Life Insurance Company
Administrative Services – PO Box 10482
Des Moines, IA 50306

www.GoMedico.com *Toll-Free 1-800-547-2401, Option 3* *Fax 515-247-2435*

Agent Credit Card Authorization

Name *(First, Last)*:_____

Billing Address:_____

City, State, ZIP Code:_____

By providing this information and signing this form, I authorize Medico Insurance Company and/or Medico Corp Life Insurance Company to charge my MasterCard/VISA account for my appointment fee(s).

☐ **MasterCard** ☐ **VISA**

Credit Card Number:_____ Expiration Date:_____

Card Security Code (CSC):_____ *The CSC (Card Security Code) number is the last 3 digits in the signature block on the back of your credit card. We are requesting this as an added security precaution.*

Name on Credit Card:_____

Agent Number if known:_____

SIGN HERE

_____ _____

Signature of Authorization *Date*