



Producer Transmittal

**PLEASE ASSIST US SO WE MAY PROCESS THIS NEW DISTRIBUTOR'S
CONTRACTS AND APPOINTMENT(S) AS QUICKLY AS POSSIBLE.**

Are all forms completed in full and signed by the Distributor?

Is all the information legible, especially the email address?

Have you signed in all areas as the Recruiter?

PLEASE COMPLETE THE INFORMATION REQUESTED BELOW.

MEDICO PRODUCER TRANSMITTAL

Name: _____

Agency: _____

Address: _____

Recruited By: _____ **Agency Code:** _____

Contract Level:

- FMO – Field Marketing Organization
- RGA – Recruiting General Agent
- MGA – Marketing General Agent
- SGA – Special General Agent
- TGA – Top General Agent
- Producer

Request Credit and Felony & Misdemeanor Reports: YES NO

Advancing – All Products: YES NO

States to Appoint (Medico pays resident fees, Distributor's account will be charged for non-resident appointment fees) _____

For Home Office use only:

Received in Home Office: _____/_____/_____

_____/_____/_____

History: _____

Coding: _____



MEDICO CONTRACTING CHECKLIST

Name: _____

Agency: _____

- Signed Agreement & Personal History**
- Signed HIPAA Business Associate Agreement**
- Signed Acknowledgement of Receipt**
- Producer Life Replacement Policies & Procedures**
- Direct Deposit Authorization**
- Copy of Errors and Omissions Insurance**
- Copy of Producer License for each state in which to be appointed**
- Copy of agency licenses, if applicable**



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 _____ **Date** _____

Request Background Investigation? YES NO

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.

IF DISTRIBUTOR IS INDIVIDUAL OR SOLE PROPRIETOR:

BY: _____
(Signature)

IF DISTRIBUTOR IS PARTNERSHIP: (all partners must sign)

BY: _____
(Signature) (Printed Name)

BY: _____
(Signature) (Printed Name)

BY: _____
(Signature) (Printed Name)

IF DISTRIBUTOR IS CORPORATION:

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

Recommended By:

Accepted:

MEDICO™ INSURANCE COMPANY

By _____

Title _____



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_____ Date_____

As it appears on bank records.

Signature_____ Date_____

If joint account.

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.

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.

1. 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 _____, _____.

(Signature)

(Name)

(Title)

(Individual, Partnership or Corporation Name)

PRODUCER LIFE REPLACEMENT POLICIES AND PROCEDURES

PURPOSE OF THESE POLICIES/PROCEDURES:

The purpose of this document is to provide guidance for the suitability of sales of life insurance and annuities to protect consumers. The goal is to ensure that all sales and replacements are suitable based on the totality of the particular applicant's circumstances, including, but not limited to:

1. The applicant's income, age and need for insurance; and
2. The values, benefits and costs of the applicant's existing insurance program, if any, when compared to the values, benefits and costs of the recommended policy or policies.

Suitable or suitability refer to a sale, replacement or recommendation for a sale or replacement that meets the needs and goals of the applicant based upon reasonable inquiry concerning the applicant's insurance objectives, financial situation, age and other relevant information. Suitability is determined based on the circumstances that exist at the time of the recommendation. These standards must be adhered to in marketing and issuing all life insurance products.

DEFINITION OF REPLACEMENT:

Replacement is a transaction in which a new policy or contract is to be purchased, and it is known or should be known by the proposing producer and/or Company that by reason of the transaction, an existing policy or contract has been or will be:

1. Lapsed, forfeited, surrendered or partially surrendered, assigned to the replacing insurer or otherwise terminated;
2. Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;
3. Amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;
4. Reissued with any reduction in cash value; or
5. Used in a financed purchase (which involves the purchase of a new policy involving the actual or intended use of funds obtained by the withdrawal or surrender of, or by borrowing from values of an existing policy to pay all or part of any premium due on the new policy. If the withdrawal, surrender or borrowing involved is used to pay premiums on a new policy issued by the same company, it is a replacement within 4 months before or 13 months after the effective date of the new policy).

Replacement is not an issue if the new policy is replacing:

1. Credit life insurance;
2. Group life insurance and annuities where there is no direct solicitation by a producer;
3. Group life insurance and annuities used to fund prepaid funeral contracts;
4. A policy with the same Company when a contractual change or conversion privilege is being exercised or when pursuant to a program filed and approved by the state Department of Insurance;

5. Life insurance under a binding or conditional receipt issued by the same Company;
6. A policy used to fund a pension or welfare plan covered by ERISA, or a plan described by IRS Code Sections 401(a), 401(k), 403(b), 414 or 457, unless the plan is funded solely by contributions an employee elects to make;
7. A policy paid for entirely by the policyholder's employer or by an association of which the policyholder is a member;
8. Nonconvertible term life insurance that will expire in 5 years or less and cannot be renewed;
9. Immediate annuities that are purchased with proceeds from an existing contract (not policy); or
10. Structured settlements.

GENERAL SUITABILITY STANDARDS:

Replacing an existing life insurance policy with a new policy is generally not in the applicant's best interest; however, replacement is not something that should be avoided altogether. There are circumstances where it may be beneficial to replace an existing policy with a new one.

Examples of situations in which replacement **MAY** be suitable:

1. When improved health or mortality across the general population results in the same insurance coverage at a lower cost. The adoption of the 2001 CSO mortality table may make a new policy more cost-effective.
2. When conversion to a new single-premium, paid-up policy eliminates the need for future payments. The applicant may benefit from a death benefit that is secure rather than making periodic payments.
3. When a new policy may provide increased benefits for the same premium or the same benefits at a lower premium.
4. When the applicant's insurance needs have changed.
5. When the applicant has a variable life policy and prefers a whole life policy which has guaranteed cash values and where investment decisions are not required.
6. When the applicant wants to remove a large loan on the existing policy by using that policy's cash value.
7. When the applicant is concerned with the insurance company or producer that issued or marketed the existing policy.
8. When the applicant's existing policy has a low guaranteed return.
9. When the applicant chooses to change the death benefit of an existing policy.
10. When an existing policy has a low minimal return or high expenses.
11. When the applicant's health has improved and the existing insurer will not consider the change in health status.
12. When the existing policy does not charge a nonsmoker a lesser premium.

Examples of situations in which replacement **MAY NOT** be in an applicant's best interest:

1. When a life insurance policy includes early surrender charges, which can reduce the amount of cash value available toward the new policy.
2. When the applicant's premium may increase, such as for a decline in the applicant's health status.
3. When there are unfavorable tax consequences caused by surrendering an existing policy, such as a potential tax on outstanding policy loans.
4. When there is no demonstrated benefit to the policyholder.

PROCEDURE FOR PRODUCER SOLICITATION:

The producer must disclose all pertinent information about new and existing policies so that the applicant can make an intelligent choice among available products. Based on the information provided by the applicant and the producer's experience, the producer must have reasonable grounds for believing that the recommended policy is suitable for the applicant.

If the policy is believed to be suitable, the producer may take an application for the life product. The producer must be sure it is documented on the application whether or not the applicant has existing life insurance or annuities in force. If the answer is "no," the producer's duties with regard to this procedure are completed. If the answer is "yes," the producer (TN producers, please see NOTE below) must comply with the following:

1. The producer must present and read Replacement Notice MI9F-4231 or M9F-4231 aloud to the applicant. The applicant must initial in the appropriate blank on the form if he or she does not want the notice read aloud. The producer must assist the applicant in completing the notice, including listing all existing life policies and/or annuities to be replaced, properly identified by name of insurer, the policyholder and contract number. If a contract number has not been assigned by the existing insurer, other identifying information such as an application or receipt number must be provided. This form must be completed in duplicate: one copy must be left with the applicant, and the other must be submitted to the Company with the application.
2. The producer must leave the original or a copy of all written or printed communications used for presentation to the applicant.* The producer must complete the certification on the bottom of Replacement Notice MI9F-4231 or M9F-4231 to verify compliance with this requirement. Any electronically presented sales material must be provided in printed form to the applicant no later than at the time of policy delivery. ***Producers may not utilize any communications that have not been reviewed and approved in advance by the Company.**

NOTE: In Tennessee, any producer who has been licensed for less than 120 days by the Tennessee Department of Commerce and Insurance must send the Company notice by certified or registered mail, at least 10 days prior to taking an application for a replacement policy, stating that the producer intends to replace existing insurance, and include the name of the existing insurer and the policy number of the policy to be replaced.

COMPANY REVIEW OF REPLACEMENTS:

Ultimately it is the responsibility of the Company to use and enforce the suitability standards it has developed in determining whether issuing a policy or contract to the applicant is suitable. All life replacements will be reviewed by the Underwriting Director of the Company. If the Underwriting Director determines that the applicant does not meet the suitability standards, or if the applicant has declined to provide the information requested, the Underwriting Director may reject the application by sending Letter 400 to the applicant. The Company will not offer or recommend replacement except when it can be clearly demonstrated that the replacement is in the best interest of the applicant and meets his or her needs, wants or desires.

A signed replacement form is required with every replacement application and with every application when the applicant has life insurance in force, even if replacement is not contemplated. If documents are not completed in their entirety they will be returned to the producer (if the application resulted from producer solicitation) for follow-up. Failure to respond to a request for additional information in a timely manner will result in declination of the application as unsuitable.

NOTE: The Company cannot accept any replacement applications from a Tennessee producer who has been licensed for less than 120 days by the Tennessee Department of Commerce and Insurance unless the producer has sent the Company notice by certified or registered mail, at least 10 days prior to taking an application for a replacement policy, stating that the producer intends to replace existing insurance, and include the name of the existing insurer and the policy number of the policy to be replaced. Once the notice has been received by the Company, the Company must immediately forward it to the existing insurer by certified or registered mail.

COMPANY REQUIREMENTS IF A COMPANY POLICY IS BEING REPLACED:

- **Conservation**

At the current time, the Company will not attempt to conserve any business. If the Company decides to start conserving, this procedure will be clarified.

Producers must contact the Company Policyholder Service Department as soon as possible when they are notified by a policyholder of a policy cancellation or surrender for cash value. If it is decided to attempt to conserve the business, the Company must provide the policyholder with a policy summary for the existing life insurance within 20 days from receipt of the notice of replacement. All materials used must be left with the policyholder.

COMPANY NOTIFICATION OF PRODUCERS REGARDING REPLACEMENT REQUIREMENTS:

The Company is responsible for notifying producers of the Policies and Procedures relevant to producer solicitation of life insurance, and the Company's position regarding the appropriateness of replacements. Each producer will be provided with a copy of the Producer Life Replacement Policies and Procedures (Form U9F-4240). Each producer must sign an acknowledgement (Form U9F-4241) stating the he or she has received, read and will adhere to guidelines as stated. **A producer is not eligible to solicit life insurance for the Company if this acknowledgement is not returned to the Company.** No applications submitted by the producer will be processed unless the Company is in receipt of this acknowledgement. A copy of the acknowledgement will be saved in the producer's file. Until the signed acknowledgement is received, a flag will not be set on the PAPR screen (the flag must be set in order for a policy sold by a particular producer to be issued). When received, the signed acknowledgement will be saved in the producer's file.

COMPLIANCE WITH THESE POLICIES AND PROCEDURES:

Violation of these policies and procedures will subject the producer to sanctions up to and including termination of appointment.

DISCLAIMER:

These Policies and Procedures were written based upon the NAIC Life Insurance And Annuities Replacement Model Regulation and state requirements. If the Company decides to sell life insurance in additional states, these Policies and Procedures will be reviewed for compliance in those states.



MEDICO™ GROUP

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

**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™ 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

Original Signature