National Insurance Benefit Coordinators, Inc.

Appointment Instructions for

CIGNA Medicare

Please complete the following:

1. _________ **Marketing Agreement:** Sign on page 10 of 18
2. _________ **Agents Contract:** Complete as needed.
3. _________ **W-9:** Complete and sign.
4. _________ **Direct Deposit Authorization Form:** Complete, sign and include copy of voided check.
5. _________ **State License:** Please provide a copy of your resident state license
6. _________ **E&O:** Please provide a copy of your E&O Certificate.

Once all information has been completed you can fax the attached information to 501-372-2221 or e-mail to karen@nibconline.com .

If you have any questions please call us at 501-372-4800.

National Insurance Benefit Coordinators, Inc.
112 Smart House Way
North Little Rock, AR 72114
(501) 372-4800 phone
(501) 372-2221 fax

IN WITNESS WHEREOF, AGENCY and AGENT have executed this Agreement as of the date first below written.

INSERT FULL LEGAL NAME OF UPSTREAM AGENCY HERE:

UPSTREAM AGENCY NAME

Sign Here

NAME:
Print Name Legibly

ITS:
Position (e.g., "President," etc.)

DATE:

INSERT FULL LEGAL NAME OF AGENT HERE:

AGENT NAME

Sign Here

NAME:
Print Name Legibly

ITS:
Position (e.g., "Agent," etc.)

DATE:

AGENCY:
(Entity Name if applicable)

TIN:
(Federal Tax Identification Number if applicable)

EXHIBITS

1: DEFINITIONS
2: APPLICATION FEES, RENEWAL FEES, AND BONUSES
3: AGENT'S CONTRACT INFORMATION SHEET
4. REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION
5: AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT

EXHIBIT 2
AGENT-1 (STREET-LEVEL) PAYMENT
CIGNA MEDICARE SELECT AND CIGNA MEDICARE RX

CIGNA shall pay Commissions to Agent in accordance with the commission level communicated by Agent's upline hierarchy to CIGNA. Agent agrees to the following compensation levels for the sale of CIGNA Medicare Plans. Note that only one (1) Agent type (Levels 5-8) may be involved in a sale of a CIGNA Medicare Plan. Agent agrees that it will indemnify and hold CIGNA harmless for any disputes between AGENT and Agent's upline hierarchy with respect to Commission amounts paid by CIGNA in accordance with upline hierarchy's transmittals to CIGNA.

1. CIGNA Medicare Select Plus Rx Plans with effective dates of January 1, 2013 or later.

a. Amount of Payment.

i. To Agent. CIGNA shall pay to the Agent identified by COMPANY for each sale of a CIGNA Medicare Select Plan the applicable First Year Payment or Renewal Payment (the "Sales Payment") set forth in the payment chart below (the "CIGNA Medicare Advantage Payment Chart"). CIGNA will determine, consistent with Medicare Laws and Regulations, whether Agent will be paid First Year Payment or Renewal Payments. Not more than one Agent shall be compensated with respect to any sale.

Sales Level	Title	First Year Payment	Lifetime Renewal Payment
5	Agent-1	$413.00	$207.00

ii. Replacement Policies. If CIGNA offers more than one type of CIGNA Medicare Advantage Plan, only Renewal Payments (and not First Year Payments) shall apply to a sale in which one type of CIGNA Medicare Advantage Plan replaces another type for the same Member.

b. Time Frames for Payments.

i. Application/First Year Payment. The First Year Payment will be paid within each semi-monthly payment cycle, which cycle commences immediately following CMS approval of the beneficiary's application and is paid in advance and subject to Section 3, "Adjustments (All Products)," below.

ii. Renewals. CIGNA shall pay Renewal Payment by the fifteenth (15th) day of each then-current month for each CIGNA Medicare Advantage plan member (a) who, as of the month immediately preceding the then-current month, has been enrolled in a Medicare Advantage Plan for at least 12 months and (b) remains enrolled and in-force throughout the month immediately preceding the then-current month and (c) whose initial enrollment was as a result of the marketing services of Agent. CIGNA Medicare Advantage payments are paid monthly at a rate of $1/12^{th}$ of the full-year rate in the CIGNA Medicare Advantage Payment Chart above.

2. CIGNA Medicare Rx Plans with effective dates of January 1, 2013 or later.

a. Amount of Payment.

i. To Agent. CIGNA shall pay the Agent identified by COMPANY for each sale of a CIGNA Medicare Rx Plan the applicable First Year Payment or Renewal Payment (the "Sales Payment") set forth in the payment chart below (the "CIGNA Medicare Rx Payment Chart"). Not more than one Agent shall be compensated with respect to any sale. CIGNA will determine, consistent with Medicare Laws and Regulations, whether Agent will be paid First Year Payment or Renewal Payments. Not more than one Agent shall be compensated with respect to any sale.

Sales Level	Title	First Year Payment	Lifetime Renewal Payment
5	Agent-1	$56.00	$28.00

ii. Replacement Policies. If CIGNA offers more than one type of CIGNA Medicare Rx Plan, only Renewal Payments (and not First Year Payments) shall apply to a sale in which one type of CIGNA Medicare Rx Plan replaces another type for the same Member.

b. Time Frames for Payments.

i. Application/First Year Payment. The First Year Payment will be paid within each semi-monthly payment cycle, which cycle commences immediately following CMS approval of the beneficiary's application and is paid in advance and subject to Section 3, "Adjustments (All Products)," below.

ii. **Renewals.** CIGNA shall pay Renewal Payments by the fifteenth (15th) day of the month, for each CIGNA Medicare Rx plan member (a) who, as of the month immediately preceding the then-current month, has been enrolled in a Medicare Rx Plan for at least 12 months and (b) whose initial enrollment was as a result of the marketing services of Agent. CIGNA Medicare Rx Renewal Payment is paid as a full-year advance, and subject to Section 4, "Adjustments (All Products)," below.

3. Adjustments (All Products).

a. Should a policy covering a CIGNA Medicare Plan Member lapse, be canceled, rescinded or otherwise terminated for any reason, any unearned portion of a First Year Payment or Renewal Payment that was advanced to Agent shall be charged back. Additionally, should CMS require CIGNA to refund a premium with respect to a CIGNA Medicare Plan Member for any reason, then upon CIGNA so informing Agent, Agent shall immediately refund CIGNA the entire First Year Payment and Renewal Payment CIGNA paid to Agent with respect to the sale of the CIGNA Medicare Plan to such Member.

b. First Year Payments and Renewal Payments will not be payable if and when CMS ceases to pay CIGNA.

c. In accordance with CMS regulations pertaining to rapid disenrollment, and notwithstanding anything in the Agreement to the contrary, if a CIGNA Medicare Plan Member disenrolls for reasons other than death within three (3) months of the effective date of enrollment (that is, in months one (1) through months three (3) following enrollment), then all First Year Payments and Renewal Payments paid and any additional compensation paid, credited or advanced on such policy shall be charged back to Agent.

d. This Exhibit 2 and any payments described hereunder may be modified by CIGNA at its sole discretion upon 10 days written notice to AGENT, except if prohibited by Medicare Laws and Regulations.

e. This Exhibit 2 will replace any previously distributed compensation exhibits for CIGNA Medicare Advantage Plans and CIGNA Medicare Rx Plans with effective dates of January 1, 2013 or later. Agent will cooperate with CIGNA to adjust payments made by CIGNA under the previous compensation exhibit to comply with CMS requirements and this new Exhibit 2. At CIGNA's sole discretion, CIGNA may offset and deduct any compensation that would otherwise be due and payable to Agent under the previous compensation exhibit to reflect such adjustments under this Exhibit 2 or Agent will make a prompt refund of any monies owed CIGNA.

f. The terms of this Agreement, except for the payment terms, will apply to services by Agent in support of the enrollment of groups (e.g., Employer/Group Waiver Plans) in the CIGNA Medicare Plans and other CIGNA retiree group plans, if such services are undertaken. Payment terms for such services will be as mutually agreed and executed in writing by CIGNA and Agent.

g. No payment otherwise payable to Agent shall accrue or be payable after the death of the Agent.

4. Termination of Agreement

a. **On Notice.** Either party (to include CIGNA) may terminate this Agreement without cause on thirty (30) days' prior written notice to the other party.

b. **For Cause.** In the event that either party fails or is unable to perform its obligations, duties, or responsibilities under this Agreement or otherwise materially breaches any term of this Agreement (a "Default"), the non-Defaulting party (to include CIGNA) may terminate this Agreement immediately upon the defaulting party's receipt of written notice of termination of this Agreement. SUB-AGENCY acknowledges and agrees that CIGNA or UPSTREAM AGENCY may, in its sole discretion, terminate the participation of an Agent under this Agreement in lieu of terminating this Agreement in its entirety. In the event of a conflict between this Section 4.b of Exhibit 2 and another section regarding termination and headed "For Cause" elsewhere in the Agreement, this Section 4.b will govern.

Cigna

EXHIBIT 3
AGENT'S CONTRACT INFORMATION SHEET

1. Agent Information:

LAST	FIRST	MI

__ __ __ – __ __ – __ __ __ __	__ __ / __ __ / __ __ __ __
SSN	DOB (MM/DD/YYYY)

(__ __ __) __ __ __ – __ __ __ __		(__ __ __) __ __ __ – __ __ __ __
PHONE	EXT	FAX

(__ __ __) __ __ __ – __ __ __ __	
MOBILE	E-MAIL ADDRESS

2. Mailing Address:

STREET ADDRESS 1

STREET ADDRESS 2

CITY	STATE	ZIP CODE

3. License Information: (Please attach copies of all licenses)

State	License Number	State	License Number

4. Background Information: (Please explain any "Yes" answers on a separate sheet. Include dates.)

		No	Yes
▪ Have you ever:	• Been convicted* of a crime, including felony, misdemeanor or military offense?	☐	☐
	• Been the subject of a penalty, inquiry or action by a regulatory agency?	☐	☐
	• Filed bankruptcy?	☐	☐
	• Had a license refused/suspended/revoked or currently restricted or under investigation?	☐	☐
▪ Do you have any outstanding judgments or liens?		☐	☐
▪ Are you indebted to any insurance company/agency/manager (including debt balance)?		☐	☐

If "Yes", please provide name and relationship

* Convicted includes a guilty verdict, withdrawn plea, probation, any dismissed charges, suspended sentences or fines. You may exclude traffic citations and juvenile offences.

5. Errors & Omissions Insurance

Do you have Errors & Omissions Insurance? ☐ Yes ☐ No

If "Yes", please provide name of carrier

EXHIBIT 4

W-9

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Name:

(as shown on your income tax return)

Check appropriate box: ☐ Individual/ Sole Proprietor ☐ Corporation ☐ Partnership ☐ Other

Address: ______________________________

(number, street and apt. or suite no.)

City: ______________________ State: __________ ZIP Code: __________

Part I Taxpayer Identification Number (TIN)

Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ **or**

Employer Identification Number: ___ ___ - ___ ___ ___ ___ ___ ___ ___

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (Or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

Sign Here	**Signature of U.S. Person:**	**Date:**

EXHIBIT 5

Direct Deposit Authorization Form	Connecticut General Life Insurance Company Direct Deposit Unit, C-328 900 Cottage Grove Rd. Hartford, CT 06152-1328 800.903.7711	

Please read the instructions on the following page prior to completing this form.

PRODUCER NAME *(Legal Entity)*	TAX IDENTIFICATION NUMBER	PRODUCER CODE

PRODUCER'S BILLING ADDRESS *(Street, City, State, Zip Code)*

CONTACT NAME	BUSINESS TELEPHONE
	( )

PLEASE INCLUDE A VOIDED CHECK OR SPECIFICAITON SHEET AS REQUESTED IN THE INSTRUCTIONS ON THE FOLLOWING PAGE. YOUR APPLICATION CANNOT BE PROCESSED WITHOUT THIS INFORMATION.

NOTE: A DEPOSIT TICKET IS NOT ACCEPTABLE

Please Check One:

☐ Cancellation ☐ Enrollment ☐ Change

BANK ACCOUNT INFORMATION

BANK ACCOUNT NUMBER	BANK ROUTING NUMBER

BANK ACCOUNT NAME

LISTED NUMBER REFERS TO: *(Please Check One)*

☐ Business Checking Account ☐ Business Savings Account ☐ Other (personal account, etc.)

BANK NAME

ADDRESS *(Street, City, State, Zip Code)*

Authorization is hereby granted to Connecticut General Life Insurance Company ("Connecticut General") and its affiliates to credit said account at the financial institution named above for the purpose of making commission payments. Connecticut General and its affiliates are also granted authorization to correct inadvertent duplicate payment information. This authorization is to remain in effect until written notification is given to Connecticut General [at least ten (10) days in advance of any change] on a Direct Deposit Authorization Form.

AUTHORIZED SIGNATURE	PRINTED NAME AND TITLE	DATE

588544 10.02