HEALTH INSURANCE INNOVATIONS
AGENT LICENSING CHECK LIST

Please complete the required forms listed below to sell the HII Plans.

1. **Complete and sign the HII Agent Statement of Understanding ***
2. **Complete and sign Agent Profile Form**
3. **Attach a copy of your Errors & Omissions Insurance**
4. **Include current copies of yours and the agency's insurance agent license(s) for each state you plan to sell the HII plans.**
   (Resident and Non-Resident)

Submitted By:_____ Date:_____
(Please Print)

Recruited By:_____

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Scan and e-mail or fax all required attachments to your GA / MGA. Please save a copy of all documents for your records.

Company: Health Insurance Innovations

E-Fax: 813-354-2399 `
Email:
scasale@hiiquote.com

Rev.10/2011

HEALTH INSURANCE INNOVATIONS (HII)
AGENT INFORMATION FORM

COMPLETE THE FOLLOWING INFORMATION ABOUT YOURSELF:

Agent Name _____ Date of Birth _____ Social Security# _____

Corporation/Agency Name _____ Tax I.D.*_____ Email _____

Business Street Address _____ City _____ St. _____ Zip _____

Resident Street Address _____ City _____ St. _____ Zip _____

Business Telephone # (_____) _____ Fax # (_____) _____ Resident Telephone # (_____) _____

** If we are to pay Marketing Fees/ Commissions to an Agency or Corporation, and you are not the Owner / Officer, we need the assignment below signed by you and we must have another License Request Form completed by the Agency Owner / Officer; and copies of their license. Include the Agency's license if applicable in your state.*

ANSWER THE FOLLOWING QUESTIONS:

1. Have you ever been convicted of a felony? ..... YES NO
2. Have you ever been involved in an investigation with any State Insurance Department? ..... YES NO
3. Has your license ever been suspended, cancelled or revoked by any State Insurance Department? ..... YES NO
4. Have you ever filed Bankruptcy, been sued or had a judgment entered against you? ..... YES NO

Any "YES" answer above requires a separate statement, including dates, location, basis of charge and legal documentation indicating disposition of case.

5. Do you carry errors and omissions coverage? YES NO (If YES, list carrier name and limits)_____
6. What lines of insurance are you licensed to sell for: Life Accident / Health Other _____
7. Please list the states where you hold a license: State _____License #_____; State _____License # _____; State _____License #_____;
   Attach copies of your resident and all nonresident licenses. ***(We do not need an appointment fee.)***

ASSIGNMENT OF MARKETING FEES / COMMISSIONS REQUEST:

Only complete the following if you want HII to pay your Marketing Fees/ Commissions to a Corp., Agency or another Agent.

I_____ Code #: _____hereby assign to Assignee:
GoHealth, LLC all of my right, title, and interest in Marketing Fees and/or renewals to which I am now entitled or become entitled, under existing contracts and agreements, heretofore entered into by and between myself and HII I hereby authorize and empower HII, to pay assignee all Marketing Fees and renewals now due or which may accrue under said contracts, for a period of one year from this date and thereafter until such time a s I terminate this assignment by written notice to HII. I agree that such payments of Marketing Fees under my contract are the same as if payment was made directly to me. I hereby covenant and agree that I am the absolute and sole owner of said Marketing Fees, free from prior assignment or any encumbrance of any kind or character whatsoever, and that I have full right and lawful authority to sell and transfer the same as aforesaid.
Witness my hand this _____day of_____, Year_____, Agent's Signature_____
CAUTION: The person assigning his or her Marketing Fees (assignor) will not recover the right to receive any further Marketing Fees during the one year period from the date of this assignment unless and until the person to whom such rights are assigned (assignee) releases, in writing, his or her rights to receive such Marketing Fees. Please be certain you understand this before signing the form. This instrument may be revoked, in writing, by the Assignor at any time after the one year period.
Address of Assignee: GoHealth, LLC 214 W. Huron Street, Chicago, IL 60654 Tax I.D.#: 263235175

STATEMENT OF UNDERSTANDING FORM:

This Statement of Understanding must be signed to be in effect, and is between undersigned Agent and Health Insurance Innovations, herein referred to HII. HII agrees to pay Marketing Fees / Commissions on the plans listed on the attached Addendum accordance with and subject to the conditions and covenants below.

- The term "monthly plan cost and paid" shall mean monies, excluding any enrollment fee, monthly administrative fee or association dues, due and paid for the plan after the effective date of this Agreement by each member and for whom the Agent is the representative of record.
- Marketing Fees / Commissions shall be payable only when Agent is (a) properly approved to transact business for HII and (b) is continuously recognized by H I as the Agent of record to receive said Marketing Fees / Commissions.
- This Agreement may be terminated by either party with a 30 days written notice but only with respect to new cases. Such terminations will have no effect on the payment of Marketing Fees / Commissions on business written prior to the effective date of termination as may otherwise be payable.
- No advertising material (on paper, over the radio or television or on the Internet) bearing HII or our product name or describing any named product distributed by HII can be produced without prior written approval from HII.
- The Agent is an independent contractor, not an employee of HII
- The Agent has no authority to act on behalf of HII, bind coverage, waive or alter any provision of the application or the Product under which membership is issued.
- Representations and opinions of the Agent are not binding on HII plans.
- By signing below I am giving HII prior written express invitation and permission to transmit facsimile and email advertisements to me.

READ CAREFULLY BEFORE SIGNING:

The above information is true and complete. I understand false statements on this form may be sufficient cause for termination. I have read the Statement of Understanding and understand that if these guidelines are not followed, the result will be termination of this Agreement.

Agent Signature:_____ Date:_____ Title: _____

MGA Name: GoHealth, LLC HII Code #: A730000000

Recruited By: A000000000

Mail your completed required forms and a copy of your current license(s) to your GA or MGA.
If none is listed, fax completed them toll free to: 1-877-376-5832
You can mail the forms to HII, 218 East Bearss Ave., Suite 325, Tampa, FL 33613

Agent Profile Form

Last Name	*First Name*	*Middle*

Social Security Number	*Gender*	*DOB*	*US Citizen*

Agency Name	*Tax ID#*

Resident Address	*City*	*State*	*Zip*

Business Address	*City*	*State*	*Zip*

Business Phone	*Cell Phone*	*Fax Number*

Email	*Website*

Preferred Mailing Address		*Business*		*Resident*

Please check off the states below, in which you will be representing HII. Please provide a current copy of insurance license(s) for each state checked. We also need a copy / proof of your E&O insurance.

If assigning commissions to an agency or corporation, please also provide a copy of the agency license (if applicable).

	AL		AK		AZ		AR		CA		CO		CT		DE
	DC		FL		GA		HI		ID		IL		IN		IA
	KS		KY		LA		ME		MD		MA		MI		MN
	MS		MO		MT		NE		NV		NH		NJ		NM
	NY		NC		ND		OH		OK		OR		PA		RI
	SC		SD		TN		TX		UT		VT		VA		WA
	WV		WI		WY										

Notice Regarding Background Checks

*Before our company may begin processing your appointment and/or license application, we are required by *federal law to ensure that all agents and/or employees we wish to do business with are not convicted criminals or felons. *(Criminal checks are based on the Violent Crime Control Act of 1994)*

We will notify you if your background report results are unfavorable and we consequently decline your license appointment. In addition, you will be advised to discontinue submission of business to our company and/or service to any of our clients as well. In the event that the information reflected in the criminal report is incorrect, we will advise you of the protocol to appeal.

Additional Information required to sell the Freedom Access Membership:

Drivers Licence Number: _____ *State Issued:* _____

Married: _____ *If YES, please list spouse's name:* _____

Last five years of employement: (list dates, company name and position with company)

_____

Fax or Mail to: Health Insurance Innovations Fax: 877.376.5832
Mailing Address: 218 E. Bearss Ave., Suite 325, Tampa, Florida 33613 APF0806