Agent "Conditions For Appointment"
JANUARY 1 – DECEMBER 31, 2009 CALENDAR YEAR

☐ CGA ☐ MAA ☐ FFB

APPOINTMENT APPLICATION

All information provided must match the information in the Office of Insurance Regulation's (OIR) database.

Agency Information: (Please complete all questions in this section)

Agency Name: _____ **Agency Code:** _____

Agency Address: _____

City: _____ **County:** _____ **State:** _____ **Zip Code:** _____

Contact person within the agency: _____ **Contact phone:** _____

Contact e-mail address: _____

Agent Information:

CMS test score: _____ **Date taken:** _____

Agent Name (Last, First, MI): _____ **Suffix:** _____

Date of Birth (mm/dd/yy): _____ **SSN:** _____ **Gender:** ☐ **M** ☐ **F**

Home Address: _____ **Telephone:** _____

City: _____ **County:** _____ **State:** _____ **Zip Code:** _____

Correspondence Address: _____

City: _____ **County:** _____ **State:** _____ **Zip:** _____ **N/A:** ☐

Telephone: _____ **Fax:** _____

E-mail Address: (This must be included in order to gain any access to the systems utilized through BCBSFL) : _____

Can Blue Cross and Blue Shield of Florida (BCBSFL) contact you via e-mail regarding company, product, promotional, sales and bonus programs: ☐ **Yes** ☐ **No**

Are you currently a resident of the State of Florida? ☐ **Yes** ☐ **No**

Are you currently licensed in the State of Florida to sell health insurance products? ☐ **Yes** ☐ **No**

(If you have a non-resident license to sell health insurance products in Florida, check yes)

License #(s) and Description:

A photocopy of the license(s) listed below must be included with this application.

License #	Type of License	State	Company

The following questions are applicable to all Agents, Agencies, Corporations, Partnerships, and other business ventures as well as to each of the partners, members, directors, officers, and agents individually. If "Yes" is utilized as any answer to the following questions, please provide a full account of the details on a separate sheet of paper and return to BCBSFL with your application.

1. Have you (or the partners, members, directors, officers, or agents of this company/ corporation/partnership) ever been convicted of a crime (whether felony or misdemeanor) other than a minor traffic violation? ☐Y ☐N
2. Have you (or the partners, members, directors, officers, or agents of this company/ corporation/partnership) ever been fined, reprimanded, sanctioned, or been the subject of a consent decree in any state for a violation of insurance laws, HMO regulations, or other administrative regulations? ☐Y ☐N
3. Have you (or the partners, members, directors, officers, or agents of this company/ corporation/partnership) ever been refused license to sell insurance/HMO products, or has a license to sell Insurance/HMO products ever been suspended or revoked by any state? ☐Y ☐N
4. Have you (or the partners, members, directors, officers, or agents of this company/ corporation/partnership) ever been employed by an Insurance/HMO company, or another organization providing for or assisting with the administration of health care or other employee benefits, where the employment contract was terminated or non-renewed because of allegations of wrongdoing? ☐Y ☐N
5. Have you (or the partners, members, directors, or agents of this company/corporation/ partnership) ever surrendered any insurance or HMO license, whether voluntary or involuntary? ☐Y ☐N
6. Have you (or the partners, members, directors, or agents of this company/corporation/ partnership) ever declared bankruptcy, had a lien placed against you or your company, been a judgment debtor, or had other problems with you or your company's credit history? ☐Y ☐N
7. Are you (or the partners, members, directors, or agents of this company/corporation/ partnership) currently names party in any lawsuit? ☐Y ☐N
8. Have you ever been short in accounts with any employer? ☐Y ☐N
9. Has an application for bond ever been declined to you? ☐Y ☐N
10. Do you have any office that is in a different location than your contracting agency location? If yes, please provide name and address below. ☐Y ☐N

Agency Name: _____ **Agency Code:** _____

Agency Address: _____

City: _____ **County:** _____ **State:** _____ **Zip Code:** _____

Contact person within the agency: _____ **Contact phone:** _____

Contact e-mail address: _____

Employment History:

Name of Present / Most Recent Employer:

Supervisor: **Job Title:** **Phone:**

Address: **City:** **State:** **Zip:**

Years of Service: **Months of Service:**

Are you currently employed with this employer at this time? ☐ **YES** ☐ **NO**

If you answered "No", what date did you disassociate?

Name of Previous Employer:

Supervisor: **Job Title:** **Phone:**

Address: **City:** **State:** **Zip:**

Years of Service: **Months of Service:**

References:

Name: **Relationship:** **Phone**:

Address: **City:** **State:** **Zip:**

Name: **Relationship:** **Phone:**

Address: **City:** **State:** **Zip:**

Language Skills:

Primary Language Written/Spoken/Read:

Secondary Language(s) Written/Spoken/Read (List all that apply):

Language (include all that apply	Dialect, region or country	Fluency level: F=Fluent, M=Moderate S=Somewhat	Do you use this language regularly in your job?	Would you be willing to use this language in your job?
		☐F ☐M ☐S	☐Yes ☐No	☐ Yes ☐ No
		☐F ☐M ☐S	☐Yes ☐No	☐ Yes ☐ No
		☐F ☐M ☐S	☐Yes ☐No	☐ Yes ☐ No

Ethnicity (Optional):
What is your Race/Ethnicity (check one): ☐ **I choose to decline this question**

☐ **White (Non-Hispanic)** ☐ **African American** ☐ **Black Caribbean**
☐ **American Indian** ☐ **Asian/Pacific Islander** ☐ **Asian Indian**
☐ **Hispanic (if Yes, please list your Ancestry – Mexican, Puerto Rican, etc):**
☐ **Other:**

*****PLEASE PRINT OUT APPLICATION, THEN SIGN AND DATE THIS PAGE BEFORE SUBMITTING TO THE AGENCY*****

Blue Cross and Blue Shield of Florida, Inc. will be obtaining a complete list of companies with which you hold a current agent appointment as listed on the State of Florida Office of Insurance Regulation (OIR) website.

I certify that I have read and understand the items on this form and that the answers to the above questions are true and complete to the best of my knowledge. If accepted, I agree to comply with all the regulations of Blue Cross and Blue Shield of Florida and the State of Florida Office of Insurance Regulations (OIR). I understand and agree that I am not permitted to solicit insurance until I have received my license from the OIR.

NOTICE: **"The Fair Credit Reporting Act" requires that we advise you that a routine inquiry may be made during our initial or subsequent processing of your application for sponsorship for license which will provide applicable information concerning your health, past history, character, general reputation, personal characteristics and mode of living. The information obtained in such an inquiry may be released to any third party, including State of Federal regulatory bodies. Upon your written request additional information as to the nature and scope of the inquiry, if one is made, will be provided.**

By signing below, I certify that I have not been convicted of any criminal felony involving dishonesty, breach of trust or been convicted of an offense under section 1033 of the Violent Crime and Law Enforcement Act of 1994. Furthermore, I agree to immediately inform Blue Cross and Blue Shield of Florida of any conviction of the types described in the preceding sentence. Finally, I hereby also understand and agree that my appointment is predicated on my compliance with the corporate policies and procedures of Blue Cross and Blue Shield of Florida and its subsidiaries including, but not limited to, the provisions of the foregoing "Privacy and Security" and "Good Standing Criteria" sections.

Signature of Applicant: _____

Date: _____

Signature of General Agent: _____

For this Subsection, "Appointed Agent" shall be referenced as "Business Associate."

1) Privacy and Security of Protected Health Information.

a) Permitted Uses and Disclosures. Except as otherwise permitted by BCBSF (hereafter referred to as "Company), Business Associate may use, disclose or request the minimum necessary Protected Health Information and Nonpublic Personal Financial Information to perform functions, activities, or services for, or on behalf of, Company as specified in this Agreement, provided that such use, disclosure or request would not violate the HIPAA-AS Privacy Rule if done by Company.

b) Prohibition on Unauthorized Use or Disclosure. Business Associate shall not use or disclose Protected Health Information or Nonpublic Personal Financial Information other than as permitted or required by Company or as required by Law.

c) Information Safeguards and Breach Reporting.

(i) Privacy of Protected Health Information. Business Associate shall use appropriate safeguards to prevent use or disclosure of Protected Health Information and Nonpublic Personal Financial Information not provided for by Company.

Business Associate shall report in writing to Company's Corporate Compliance Office any use or disclosure or Protected Health Information or Nonpublic Personal Financial Information not provided for by Company as soon as practicable but no later than five (5) days after Business Associate becomes aware of such unauthorized use or disclosure. Unless otherwise directed by Company's Corporate Compliance Office, Business Associate shall include in the report the following:

(A) the date of the unauthorized use or disclosure;

(B) the name and (if known) address of the person or entity which received Protected Health Information pursuant to the unauthorized disclosure;

(C) a brief description of the Protected Health Information that was subject of the unauthorized use or disclosure;

(D) a brief statement of the nature of the unauthorized use or disclosure;

(E) the name and date or birth of the individual(s) whose Protected Health Information was the subject of the

unauthorized use or disclosure, and each such individual's contract number;

(F) the corrective action that Business Associate has taken or will take to prevent further unauthorized uses or disclosures; and

(G) the steps Business Associate has taken or will take to mitigate any known harmful effects of the unauthorized use or disclosure.

(ii) Security of Electronic Protected Health Information. Business Associate shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic Protected Health Information.

d) Business Associate shall report in writing to Company's Corporate Compliance Office any successful Security Incident as soon as practicable but no later than five (5) days after Business Associate becomes aware of such Security Incident and shall submit follow-up documentation pursuant to the direction of Company's Corporate Compliance Office. Upon Company's request and pursuant to Company's direction, Business Associate shall report in writing any attempted but unsuccessful Security Incident of which Business Associate becomes aware. Business Associate shall comply with this Section 1(d)(ii) upon the later or (1) April 20, 2005; or (2) the effective date of appointment.

e) Mitigation. Business Associate shall mitigate to the extent practicable any harmful effect of which Business Associate is aware that is caused by any use or disclosure or Protected Health Information or Nonpublic Personal Financial Information not provided for by Company.

f) Agents and Subcontractors. Business Associate shall ensure that its agents and subcontractors to whom it provides Protected Health Information agree in writing to the same privacy and security restrictions and conditions that apply to Business Associate with respect to such information.

g) Business Associate Guidance. Business Associate shall comply with any policy, procedure or guidance with respect to Business Associate's responsibilities under Sections E that Company may, from time to time, issue and communicate in writing to Business Associate.

2) Management or Protected Health Information.

a) Access. Business Associate shall, within seven (7) days following Company's request, make available to Company for inspection and

copying Protected Health Information about an individual that is in Business Associate's custody or control, so that Company may meet its access obligations under the HIPAA-AS Privacy Rule.

b) Amendment. Business Associate shall, within fourteen (14) days following Company's request, amend or permit Company to amend any portion of Protected Health Information that is in Business Associate's custody or control so that Company may meet its amendment obligations under the HIPAA-AS Privacy Rule.

c) Disclosure Accounting. Business Associate shall record the information specified below ("disclosure information") for each disclosure of Protected Health Information that Business Associate makes, excluding disclosures identified in 45 CFR Subsection 164.528(a)(1) including but not limited to disclosures for Treatment, Payment, and Health Care Operations and disclosures pursuant to a HIPAA-AS compliant authorization, and shall report the disclosure information to Company's Corporate Compliance Office at P.O. Box 44283, Jacksonville, Florida 32203-4283 in writing within five (5) days of Business Associate making the accountable disclosure. Disclosure information shall include:

- **(i) the disclosure date;**
- **(ii) the name and address (if known) of the person or entity to which Business Associate made the disclosure;**
- **(iii) a brief description of the Protected Health Information disclosed;**
- **(iv) a brief statement of the purpose of the disclosure;**
- **(v) the name and date of birth of the individual whose Protected Health Information was disclosed; and**
- **(vi) that individual's contract number.**

d) Inspection of Internal Practices, Books and Records. Business Associate shall make its internal practices, books and records relating to its use and disclosure of Protected Health Information and its protection of the confidentiality, integrity, and availability of Electronic Protected Health Information available to Company and the U.S. Department of Health and Human Services ("HHS") as requested or required to determine Company's compliance with the HIPAA-AS Privacy Rule and Security Rule.

3) Breach of Privacy and Security Obligations.

a) Termination

- **(i) Company and Business Associate specifically acknowledge and agree that a breach of any term of the "Privacy & Security" subsection of the Conditions for Appointment (the "Subsection") shall be considered a breach of a material term of the Conditions and Company may terminate the Agent's appointment.**

b) Obligations on Termination

(i) Return or Destruction of Protected Health Information. Upon termination of the Agent's appointment, Business Associate shall, if feasible, return to Company or destroy all Protected Health Information in its custody or control in whatever form or medium, including all copies and all derivative data, compilations, and other works that allow identification of any individual who is a subject of the Protected Health Information. Business Associate shall in writing identify to Company any Protected Health Information that cannot feasibly be returned to Company or destroyed and explain why return or destruction is unfeasible. Business Associate shall limit further use or disclosure of such Protected Health Information to those purposes that make its return or destruction unfeasible. Business Associate shall complete these obligations as promptly as possible, but not later than thiry (30) days following the effective date of the termination of the Agent's appointment.

(ii) Continuing Privacy and Security Obligations. Business Associate's obligation to protect the privacy and confidentiality and safeguard the security of Protected Health Information as specified in the Conditions shall be continuous and survive termination of the Agent's appointment.

4) General Provisions for the Subsection.

a) Definitions. The terms "Electronic Protected Health Information" and "Protected Health Information" have the meanings set out in 45 CRF Subsection 160.103, except Protected Health Information shall be limited to that information created or received by Business Associate from or on behalf of Company. The term "Required by Law" has the meaning set out in 45 CFR Subsection 164.103. The term "Security Incident" has the meaning set out in CRF Subsection 164.304. The terms "Health Care Operations", "Payment", and "Treatment" have the meanings set out in 45 CFR Subsection 164.501. For purposes of this Addendum, Protected Health Information encompasses Company's Electronic Protected Health Information. The term "Nonpublic Personal Financial Information" has the meaning set out in Fla. Admin. Code Subsection 4-128.002 except Nonpublic Personal Financial Information shall be limited to that information created or received by Business Associate from or on behalf of Company.

b) Amendment to the Subsection. The Subsection shall automatically amend upon the compliance date of any final regulation or amendment to final regulation promulgated by HHS or a Florida regulatory agency concerning the subject matter of the Subsection such that Business Associate's obligations remain in compliance with the final regulation or amendment to final regulation, unless Company or Business Associate elects to terminate Section E by giving the other party written notice of termination at least ninety (90) days before the compliance date of such final regulation or amendment to final regulation.

c) **No Third Party Beneficiaries. No party shall be deemed a third party beneficiary of the Subsection.**

Good Standing Criteria

In order for an Appointed Agent to remain in good standings with the Company and maintain their Appointment as an Appointed Agent for Company, an Appointed Agent:

1. **Must comply with the Conditions for Appointment.**
2. **Must comply with all Blue Cross and Blue Shield of Florida and its subsidiaries and affiliates, corporate policies and procedures.**
3. **Must have active inventory or a minimum of 100 Contracts ("Contracts" may be individual or group policies from either health or ancillary products) (for the purposes of this document, the "minimum inventory standard") which inventory will be evaluated.**
    i. **At the end of the initial twelve (12) month period calculated from the date of appointment; and**
    ii. **At the end of every subsequent twelve (12) month period thereafter.**
4. **If the Appointed Agent satisfies this minimum inventory standard, Company will pay to renew their Appointment; however,**
    i. **If at any time the Appointed Agent does not satisfy the minimum inventory standard, or their Appointment is terminated by the State of Florida for any reason, the Appointed Agent may be required to reimburse Company or Agency for the Appointment Fees Company paid on their behalf subject to the agreement between Company and Agency.**
    ii. **In the event the Appointed Agent fails to reimburse Company or submit renewal Appointment Fees, Company shall, within thirty (30) calendar days, terminate the Appointed Agent's Appointment and Company shall cease commission payment(s) to the Designated Producer.**
5. **Must have a valid Florida resident health and life agent license.**
6. **Must have on file with Company a fully executed Conditions for Appointment form.**
7. **Must provide evidence that all continuing education credits/coursework requirements have been met.**
8. **Is prohibited from writing any individual competitor products (over 65 and under 65) outside of BCBSFL Guidelines. (Please see your contracting agency for further details on this.)**
9. **Must meet the minimum production requirements. (Please see your Contracting agency for further details on this subject.)**