



Harvard Pilgrim
HealthCare

Agent Contracting Checklist – HPHC Medicare Advantage

To expedite the contracting process, please follow the steps below:

Step 1: Complete and Sign the Following Items:

- ☐ **Broker Application** *(required)*
Be sure to indicate if contracting as an individual or corporation
- ☐ **Agent Agreement** *(required)*
- ☐ **Broker Agreement** *(required)*
- ☐ **Broker Agreement First Amendment**
- ☐ **Business Associate Agreement**
- ☐ **EFT/Direct Deposit Authorization** *(optional)* with Copy of Voided Check
Mail the EFT & check directly to HPHC – see address on form
- ☐ **W-9** *(required)*
- ☐ **Copy of State License(s)** *(required)*
- ☐ **Copy of E&O Certificate – minimum \$1,000,000 coverage** *(required)*

Step 2: Return completed contracting material to us via email or fax:

Email: contracting@garityadvantage.com
Fax: 339-469-8155
Mail: GarityAdvantage Agencies
17 Accord Park Drive, Suite 107
Norwell, MA 02061

Questions? Call 800-234-9488



Harvard Pilgrim Health Care — Broker Application

Please type or print your answers. Use a separate answer sheet if necessary.

A. Background

1. Name of firm: _____

2. Principal Address: _____

3. Mailing Address (if different from above): _____

4. Telephone: _____ Fax: _____

5. Email: _____

6. Type of firm (check one): ☐ Corporation ☐ Partnership ☐ Individual

7. Taxpayer I.D. Number: _____

8. Is the firm currently engaged in, owned or controlled by any other business interest? ☐ Yes ☐ No

If yes, explain: _____

B. Primary Contacts

| Name | Title | Email |
|------|-------|-------|
| | | |
| | | |
| | | |
| | | |

- In order to complete your application in full you must submit a copy of broker license and errors and omissions coverage.
- You must also complete Harvard Pilgrim Health Care's Broker Agreement and Business Associate Agreement contract. Please contact Broker Relations at 1-800-424-7285 for a copy of the contract.

I verify that the information contained herein is true and that I am a licensed health insurance broker in good standing with the regulatory authorities. Please direct any questions to Broker Relations at (800) 424-7285. Mail the completed form to Broker Relations, Harvard Pilgrim Health Care, 93 Worcester Street, Wellesley, Massachusetts 02481 or fax to (617) 509-2515.

Signature: _____ Date: _____

HARVARD PILGRIM HEALTH CARE, INC.

AGENT AGREEMENT

This AGENT AGREEMENT (this “Agreement”) is made and entered into this ____ day of _____, 20____, by and between Harvard Pilgrim Health Care, Inc. (“Harvard Pilgrim”), on behalf of itself and its Affiliates (collectively, the “Company”) and _____ (“Agent”).

A. Harvard Pilgrim and certain of its Affiliates offer Medicare Advantage Plans, including prescription drug plans (“MA-PD Plans”) and other health plans and products as may be designated by the Company (collectively, the “Products”).

B. Agent, or General Agent or FMO on behalf of Agent, has been recommended to the Company to market and promote the Products.”

NOW, THEREFORE, in consideration of the mutual covenants in this Agreement, it is agreed as follows:

ARTICLE ONE DEFINITIONS

1.1 **Affiliate** is any entity which directly or indirectly, through one or more intermediaries, owns or controls, is controlled or owned by or is under common ownership or control with Harvard Pilgrim, and offers one or more of the Products.

1.2 **CMS** is the Centers for Medicare & Medicaid Services.

1.3 **CMS Contract** is the contract entered into by CMS and the Company pursuant to which the Company offers the MA-PD Plans in a specified service area or region.

1.4 **Field Marketing Organization (FMO)** is an independent contractor, who or which has entered into a contract with Company for the marketing and promotion of the Products and has directly or indirectly through a General Agent recommended Agent for appointment by the Company to market and promote the Products.

1.5 **General Agent** is an appropriately licensed, independent contractor, appointed by the Company, free to exercise his or its own judgment as to the time and manner of performing services pursuant to an agreement between the General Agent and the Company and authorized to recommend another agent for appointment as a General Agent, Agent or Solicitor Agent. A General Agent can be categorized in any one of three levels, General Agent (GA), Super General Agent (SGA) or Master General Agent (MGA). For clarification, an SGA can recommend an MGA, GA, Agent and Solicitor; and an MGA can recommend a GA, Agent, and Solicitor.

1.6 **MA Plan** is any Medicare Advantage Plan that may now or in the future be offered to individual Medicare beneficiaries by the Company and subject to this Agreement, including, but not limited to, Local HMO and PPO Plans (“Local MA Plans”), Special Needs Plans (“SNPs”), Regional Preferred Provider Plans, and Private Fee for Service Plans (“PFFS Plans”). The definition of MA Plan includes MA Plans which include prescription drug plan benefits (“MA-PD Plans”).

agreement or instrument, and each such party forever waives any such defense.

5.12 **Counterparts.** This Agreement may be executed in several counterparts, each of which shall be an original, and all of which together shall constitute but one and the same instrument.

5.13 The following exhibits and attachments are incorporated by reference into this Agreement:

| | | |
|---|------------------|-----------------------------------|
| — | Exhibit A | Agent Compensation Schedule |
| — | Exhibit B | Responsibilities and Duties |
| — | Exhibit C | Medicare Regulatory Addendum |
| — | Exhibit D | HIPAA Business Associate Addendum |
| — | Exhibit E | Products |

Executed this _____ day of _____, 20__ .

AGENT CONTRACTING AS
(Check one)
INDIVIDUAL
PARTNERSHIP
CORPORATION

HARVARD PILGRIM HEALTH CARE, INC.,
on behalf of itself and its Affiliates

By: _____
Authorized Signature

Title: _____

Print Name as it Appears on License

By: _____

Title: _____

Address

City State Zip Code

Telephone Number: _____

Fax Number: _____

E-mail: _____

Tax I.D. Number: _____

If agent is contracted through one of Harvard Pilgrim's authorized General Agents or Field Marketing Organizations (FMO), complete the following:

Name of General Agent/FMO: Garity Associates

General Agents/FMO Tax ID# _____

BROKER AGREEMENT

This Agreement is made this ___ day of _____ 20___ (the "Effective Date"), by and between Harvard Pilgrim Health Care, Inc., on behalf of itself and all present and future affiliates (hereinafter referred to as "HPHC"), and _____, on behalf of itself as an individual broker or broker organization, and if a broker organization, also on behalf of any present and future employees, ("Broker").

WHEREAS, HPHC is a health plan in the business of selling health insurance products in New England;

WHEREAS, Broker is a licensed insurance producer in the business of selling such health insurance products to employer groups in one or more of the states in which HPHC does business; and

WHEREAS, Broker desires to offer HPHC's health insurance products to its employer group clients or to individuals subject to the terms and conditions set forth in this Agreement;

NOW THEREFORE, in consideration of the promises, mutual covenants and agreements set forth herein, the parties hereto agree as follows:

1. **Scope of Agreement.** Broker hereby agrees to perform services as described below, and HPHC agrees to compensate Broker as provided herein.
2. **Duties of Broker.** Broker agrees:
 - (a) to use reasonable efforts to promote and publicize HPHC's health care insurance product(s) (the "Product(s)"), to procure applications to purchase the Product(s) from Qualified Groups, as herein defined, or from individuals, to assist HPHC personnel in similar activities, and to help serve and renew existing Qualified Groups and individuals. A Qualified Group is an employer group that is (i) either newly enrolling or renewing in an HPHC Product, and (ii) meets HPHC's underwriting guidelines. To the extent permitted under applicable state or federal law, HPHC reserves the right to accept or reject, at its sole discretion, any applications.
 - (b) to make reasonable efforts to become familiar with HPHC's Product(s) and applicable guidelines, including attendance at HPHC-sponsored training sessions, seminars and other meetings that may be required by HPHC from time to time;
 - (c) to provide in a manner mutually agreed upon by HPHC and Broker all necessary follow-up and support services to: (1) each Qualified Group whose application to purchase the Product(s) is accepted by HPHC and on whose account Broker has earned commissions ("Commission Group"), and (2) each individual whose application to purchase an individual Product(s) is accepted by HPHC and on whose account Broker has earned commissions ("Individual Commission") ;
 - (d) to maintain office and staff reasonably adequate for the performance of all services described in this Agreement;
 - (e) to conform with all applicable HPHC underwriting guidelines and procedural rules related to the performance of Broker's services; and
 - (f) if any premiums paid by Commission Groups or individuals are adjusted or refunded, to refund to HPHC the entire commission previously paid to Broker on such adjusted or refunded

IN WITNESS WHEREOF the parties hereto have executed this Agreement effective the day and year first above written.

Harvard Pilgrim Health Care, Inc.

By:  _____
Vincent Capozzi, SR VP Sales and Marketing

BROKER: _____
Name of Company

By: _____
Name/Title

Address: _____

Telephone Number: _____

E-mail address: _____

Date: _____

Massachusetts License Number: _____

Maine License Number _____

New Hampshire License Number: _____

Other State License Number: _____

FIRST AMENDMENT OF BROKER AGREEMENT

This First Amendment of the Harvard Pilgrim Health Care Broker Agreement (the "Amendment"), dated as of _____ to be effective as of October 1, 2011, is made and entered into by and between Harvard Pilgrim Health Care, Inc., a Massachusetts non-profit corporation, on behalf of itself and all present and future affiliates (hereinafter referred to as "HPHC"), and _____ - _____, on behalf of itself as an individual broker or broker organization, and if a broker organization, also on behalf of any present and future employees ("Broker").

WHEREAS, HPHC and Broker entered into the Harvard Pilgrim Health Care Broker Agreement so that Broker could offer HPHC's health insurance products to its employer group clients subject to the terms and conditions set forth in such Agreement; and

WHEREAS, HPHC is now expanding the health insurance products that Broker may offer to include individual health insurance products; and

WHEREAS, Broker desires to offer such individual health insurance products to its individual clients;

NOW, THEREFORE, in consideration of the promises, mutual covenants and agreements set forth herein, the parties hereto agree as follows:

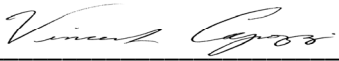
1. The second Whereas clause of the Broker Agreement is amended by deleting the clause in its entirety and replacing it with a new Whereas clause as follows: "WHEREAS, Broker is a licensed insurance producer in the business of selling such health insurance products to employer groups in one or more of the state(s) in which HPHC does business; and"
2. The third Whereas clause of the Broker Agreement is amended by adding after the words "group clients" the words "or to individuals"
3. Section 2(a) of the Broker Agreement is amended by adding after the words "as herein defined," the words "or from individuals,"; and adding after the words "renew existing Qualified Groups" the words "and individuals"
4. Section 2 (c) of the Broker Agreement is amended by deleting subsection (c) in its entirety and replacing it with a new subsection (c) as follows:
 - c) To provide in a manner mutually agreed upon by HPHC and Broker all necessary follow-up and support services to : (1) each Qualified Group whose application to purchase the Product(s) is accepted by HPHC and on whose account Broker has earned commissions ("Commission Group") and (2) each individual whose application to purchase an individual Product(s) is accepted by HPHC and on whose account Broker has earned commissions ("Individual Commission");
5. Section 2(f) of the Broker Agreement is amended by adding after the words "Commission Groups" the words "or individuals"

Broker. This Agreement shall be automatically amended to incorporate the changes set forth in the written notice unless Broker objects to such changes in writing within fifteen (15) days of receipt of such notice. If Broker objects in a timely manner to such amendment, the Parties shall work in good faith to reach agreement on a change to the Agreement. If the Parties are unable to reach agreement on a change to the Agreement within thirty (30) days of the date that HPHC receives written objection from Broker, then either Party may terminate this Agreement upon written notice of such termination."

19. The Broker Agreement is amended by renumbering the prior section 19 as section 20.
20. The Broker Agreement is amended by adding after the signature line for Broker four new lines with the captions "Address:", "Telephone Number:", "E-mail address:", and "Date:"
21. The Broker Agreement is amended by adding after the signature lines, in the list of state license numbers, a new line as follows: "Other State License Number:_____"
22. Integration. This Amendment together with the Broker Agreement (together with any Exhibits thereto) constitute the entire agreement of the Parties and supersede all prior agreements and undertakings, both written and oral, between the parties with respect to the subject matter hereof.

IN WITNESS WHEREOF, the parties hereto have executed this Amendment effective the day and year first above written.

Harvard Pilgrim Health Care, Inc.

By: 
Vincent Capozzi, Sr. VP Sales and Customer Service
Name/Title

Broker _____

Name of Company

By: _____

Principal/Title

Date: _____

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement (“Agreement”) is entered into and is in effect as of _____(mm/dd/yyyy), by and between **HARVARD PILGRIM HEALTH CARE, INC.**, a Massachusetts non-profit corporation licensed as a health maintenance organization under the laws of Massachusetts, on behalf of itself and all present and future affiliates (hereinafter referred to as the “Covered Entity”) and

[Broker], on behalf of itself as an individual broker or broker organization, and if a broker organization, also on behalf of any present and future employees (hereinafter referred to as “Business Associate”) (collectively the “Parties”).

WHEREAS, the Parties wish to enter into or have entered into an arrangement (“Arrangement”) whereby Business Associate will provide certain services to Covered Entity and, in providing those services, Business Associate may create, receive, maintain or transmit from, or on behalf of, Covered Entity Protected Health Information (“PHI”) (defined below) and may create, receive, maintain or transmit Electronic Protected Health Information (“EPHI”)(defined below)(PHI and EPHI are collectively referred to herein as PHI or Protected Health Information; EPHI will be used when only EPHI is being referenced);

WHEREAS, Covered Entity and Business Associate intend to protect the privacy and provide for the security of any PHI which shall be disclosed to or created by Business Associate pursuant to the Arrangement, in compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (“HIPAA”), the implementing regulations at 45 CFR Parts 160, 162, and 164 promulgated by the United States Department of Health and Human Services (“HIPAA Regulations”), the requirements of the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 (the “HITECH Act”) that are applicable to business associates, along with any guidance or regulations issued by the U. S. Department of Health and Human Services (“DHHS”), and other applicable laws;

WHEREAS, as part of the HIPAA Regulations, the Privacy and Security Rule (defined below) requires Business Associate to enter into a contract containing specific provisions intended to preserve the confidentiality and security of PHI obtained by Business Associate in the course of its business relationship with Covered Entity (defined below) prior to any disclosure of the PHI to Business Associate. The specific provisions are set forth in, but not limited to, Title 45, Sections 164.306, 164.308(b), 164.314(a) and (b), 164.502(e) and 164.504(e) of the Code of Federal Regulations and are applicable to this Agreement; and

WHEREAS, Business Associate agrees to comply with all other applicable federal and state laws for the protection of personal information and the reporting of security breach

incidents, including the General Laws of Massachusetts Chapter 93H, and implementing regulations at 201 CMR 17.00, New Hampshire Revised Statutes Chapter 359-C, Maine Revised Statutes Chapter 210-B, and Connecticut General Statutes, Chapters 669 (section 36A-701B) and 743dd (hereinafter “the applicable state laws”).

NOW THEREFORE, in consideration of the mutual promises below, and the exchange of PHI pursuant to the terms of this Agreement, the Parties agree as follows:

1.0 DEFINITIONS


As used in this Agreement, the following terms shall have the indicated meaning. Capitalized terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in the HIPAA Regulations and the HITECH Standards (defined below), or for Personal Information, the definition found in the applicable state laws. The definitions below which set forth a reference to the Code of Federal Regulations are defined HIPAA terms, and such definitions are incorporated herein as though set forth in full. A change to the HIPAA Regulations or the HITECH Standards which modifies any defined term, or which alters the regulatory citation for the definition shall be deemed incorporated into this Agreement.

- 1.1 **Arrangement** means the agreement, either with or without a written contract, between Covered Entity and Business Associate, whereby Business Associate provides or will provide certain services to Covered Entity and, in providing those services, may have access to PHI.
- 1.2 **Authorization** shall have the meaning given to the term under the Privacy and Security Rule, including, but not limited to, 45 CFR Section 164.508.
- 1.3 **Breach** shall have the same meaning as the term “breach” in Section 13400 of the HITECH Act and shall include the unauthorized acquisition, access, use, or disclosure of PHI that compromises the security or privacy of such information. For purposes of Personal Information, the term “Breach of Security” shall have the meaning given in the applicable state laws.
- 1.4 **Business Associate** shall mean _____[Broker].
Where the term “business associate” appears without initial capital letters, it shall have the meaning given to such term under the Privacy and Security Rule, including, but not limited to, 45 CFR Section 160.103.
- 1.5 **Covered Entity** shall mean Harvard Pilgrim Health Care, Inc., as defined. It shall also have the meaning given to the term under the Privacy and Security Rule, including, but not limited to, 45 CFR Section 160.103.

IN Witness Whereof, the Parties hereto have duly executed the Agreement.

**HARVARD PILGRIM
HEALTH CARE, INC.**

BUSINESS ASSOCIATE

By:  By: _____

Name: Vincent Capozzi Name: _____

Senior Vice President
Title: Sales and Marketing Title: _____

Date: _____ Date: _____



Harvard Pilgrim
Health Care

Electronic Funds Transfer (EFT) Form

Please choose one of these options:

☐

Elect EFT payments

☐

Change EFT information

☐

Terminate EFT payments

Name of Brokerage Firm: _____

Name of Broker: _____

Business Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Please attach a voided check. When providing the Account and Routing/Transit Numbers, please refer to the series of numbers located at the bottom of your check and insert those numbers located between the symbols shown. For your reference, please see the sample check on the reverse side of this form.

Type of Account: ☐ Business Account or ☐ Personal Account (check one)
☐ Checking or ☐ Savings (check one)

Name(s) on Account: _____

Please list all names that appear on the account

Account Number: ■ _____ ■

Name of Financial Institution: _____

City: _____ State: _____

Routing/Transit Number: ■

| | | | | | | | | |
|--|--|--|--|--|--|--|--|--|
| | | | | | | | | |
|--|--|--|--|--|--|--|--|--|

 ■

IMPORTANT NOTE: It is the applicant's responsibility to ensure that the information provided on this form is complete and accurate. Harvard Pilgrim will not be responsible and shall be held harmless for errors made in EFT payments that are a result of inaccurate or incomplete information provided on this form. In no event and under no circumstances will Harvard Pilgrim's liability exceed the amount of the EFT payments in question.

Signature of Account Owner _____ Date _____

Signature of Brokerage Firm Authorized Representative _____ Date _____

Print Name _____

Print Name _____

Title _____

Title _____

To protect the privacy of your financial information, please **DO NOT fax or e-mail completed forms**. Please mail your signed and completed forms to the following address: Harvard Pilgrim Health Care, Inc., Treasury Department, 93 Worcester Street, Wellesley, MA 02481

For Internal Use Only:

Vendor ID #

This information refers to products and services offered by Harvard Pilgrim Health Care and its affiliates, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

Request for Taxpayer Identification Number and Certification

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

| | | |
|---|--|---|
| Print or type See Specific Instructions on page 2. | Name (as shown on your income tax return) | |
| | Business name/disregarded entity name, if different from above | |
| | Check appropriate box for federal tax classification: <input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____ <input type="checkbox"/> Other (see instructions) ▶ _____ | |
| | <input type="checkbox"/> Exempt payee | |
| | Address (number, street, and apt. or suite no.) City, state, and ZIP code List account number(s) here (optional) | Requester's name and address (optional) |

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

| | | | | | | | | | | |
|------------------------|--|--|--|---|--|--|--|---|--|--|
| Social security number | | | | | | | | | | |
| | | | | - | | | | - | | |

| | | | | | | | | | | |
|--------------------------------|--|--|--|---|--|--|--|--|--|--|
| 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. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.

| | | |
|------------------|-------------------------------|--------|
| Sign Here | Signature of U.S. person ▶ | Date ▶ |
|------------------|-------------------------------|--------|

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.