



NAME: _____ **Date:** _____

Agent Contracting Checklist:

- Licensing for each market (PA, MD, DC, TX and NJ) *(where applicable)*
- Assignment of Commissions form
- Hierarchy Form
- Background release form and date of birth
- Agent Application**
 - All 3 pages filled out in their entirety
- W-9
 - ACH Form-----*(where applicable)*
- Agent/ Broker Agreement**
Pages 1, 12, 13, 14, 21, 22 and 30
- Policy and Procedure Sign Off Sheet



Agent Contracting Checklist

Thank you for your interest in joining Bravo Health's sales distribution network! Below you will find a list of all forms and applications necessary to become appointed and authorized to sell Bravo Health products.

Under this agreement, you will be agreeing to solicit business on behalf of Bravo Health. Your agreement is not effective until all requirements are met for contracting and certification and an Agent writing number is assigned.

The following documents apply to all states. Please check off each item prior to submission:

- ! **State Specific Agent/Agency Agreement**
 - original signature required

- ! **E&O (Only for agencies)**

- ! **Agent HIPPA Amendment**
 - original signature required

- ! **Agent Application**
 - original signature required

- ! **Broker Code of Ethics**
 - Signed by Agent

- ! **Licensing for State/s conducting business**
 - Must be current

- ! **W-9**

- ! **P&P verification form**
 - Signed by Agent

- ! **Assignment of Commissions Form(If applicable)**
 - Signed by Agent**
- ! **Direct Deposit Form and Voided Check**
- ! **Sign the release authorization to conduct a background investigation**

For additional information, please contact Bravo Health at 866.442.7516

**Please submit all contracting/licensing paperwork to:
contracting.mailbox@bravohealth.com mailbox or efax to 410-537-8959.**



Bravo Health

RELEASE AUTHORIZATION AND FAIR CREDIT REPORTING ACT DISCLOSURE

The applicant for contracting acknowledges that this company may now, or at any time while contracted, verify information within the contract. In the event that information from the report is utilized in whole or in part in making an adverse decision, before making the adverse decision, we will provide to you a copy of the consumer report and a description in writing of your rights under the Fair Credit Reporting Act, 15 U.S.C. § 1681 et seq.

Please be advised that we may also obtain an investigative consumer report including information as to your character, general reputation, personal characteristics, and mode of living. This information may be obtained by contacting your present and previous employers or references supplied by you. Please be advised that you have the right to request, in writing, within a reasonable time, that we make a complete and accurate disclosure of the nature and scope of the investigation requested.

Additional information concerning the Fair Credit Reporting Act, 15 U.S.C. § 1681 et seq., is available at the Federal Trade Commission's web site (<http://www.ftc.gov>).

By signing below, I hereby authorize all entities having information about me, including present and former employers, personal references, criminal justice agencies, departments of motor vehicles, schools, licensing agencies, and credit reporting agencies, to release such information to the company or any of its affiliates or carriers. I acknowledge and agree that this Release and Authorization shall remain valid and in effect during the term of my contract.

For California*, Minnesota, and Oklahoma Applicants Only: *A consumer credit report will be obtained through Business Information Group, Inc., P.O. Box 541, Southampton, PA, 18966..*

*If an **investigative consumer report** and/or consumer report is processed, I understand that I am entitled to receive a copy. I have indicated below whether I would like a copy. Yes _____ No _____*

Initials Initials

Date: _____ Signature of Applicant: _____

Print Name: _____

Para informacion en espanol, visite www.ftc.gov/credit o escribe a la FTC Consumer Center, Room 130-A 600 Pennsylvania Ave. N.W., Washington, D.C. 20580.

A Summary of Your Rights Under the Fair Credit Reporting Act

*The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. **For more information, including information about additional rights, go to www.ftc.gov/credit or write to: Consumer Response Center, Room 130-A, Federal Trade Commission, 600 Pennsylvania Ave. N.W., Washington, D.C. 20580.***

- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment - or to take another adverse action against you - must tell you, and must give you the name, address, and phone number of the agency that provided the information.
- **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your "file disclosure"). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
 - a person has taken adverse action against you because of information in your credit report;
 - you are the victim of identify theft and place a fraud alert in your file;
 - your file contains inaccurate information as a result of fraud;
 - you are on public assistance;
 - you are unemployed but expect to apply for employment within 60 days. In addition, by September 2005 all consumers will be entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.ftc.gov/credit for additional information.
- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.
- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.ftc.gov/credit for an explanation of dispute procedures.
- **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.

- **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.
- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need -- usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.
- **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.ftc.gov/credit.
- **You may limit "prescreened" offers of credit and insurance you get based on information in your credit report.** Unsolicited "prescreened" offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-5-OPTOUT (1-888-567-8688).
- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
- **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.ftc.gov/credit.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. Federal enforcers are:

<i>Type of Business:</i>	<i>Contact</i>
<i>Consumer reporting agencies, creditors and others not listed below</i>	<i>Federal Trade Commission: Consumer Response Center - FCRA Washington, DC 20580 1-877-382-4357</i>
<i>National banks, federal branches/agencies of foreign banks (word "National" or initials "N.A." appear in or after bank's name)</i>	<i>Office of the Comptroller of the Currency Compliance Management, Mail Stop 6-6 Washington, DC 20219 800-613-6743</i>
<i>Federal Reserve System member banks (except national banks, and federal branches/agencies of foreign banks)</i>	<i>Federal Reserve Board Division of Consumer & Community Affairs Washington, DC 20551 202-452-3693</i>
<i>Savings associations and federally chartered savings banks (word "Federal" or initials "F.S.B." appear in federal institution's name)</i>	<i>Office of Thrift Supervision Consumer Complaints Washington, DC 20552 800-842-6929</i>
<i>Federal credit unions (words "Federal Credit Union" appear in institution's name)</i>	<i>National Credit Union Administration 1775 Duke Street Alexandria, VA 22314 703-519-4600</i>
<i>State-chartered banks that are not members of the Federal Reserve System</i>	<i>Federal Deposit Insurance Corporation Consumer Response Center, 2345 Grand Avenue, Suite 100 Kansas City, Missouri 64108-2638 1-877-275-3342</i>
<i>Air, surface, or rail common carriers regulated by former Civil Aeronautics Board or Interstate Commerce Commission</i>	<i>Department of Transportation, Office of Financial Management Washington, DC 20590 202-366-1306</i>
<i>Activities subject to the Packers and Stockyards Act, 1921</i>	<i>Department of Agriculture Office of Deputy Administrator - GIPSA Washington, DC 20250 202-720-7051</i>



HIERARCHY ASSIGNMENT FORM

Solicitor Name _____

Agent Name _____

GA Name _____

MGA Name _____

SGA Name _____

FMO Name _____

Solicitor: Agent assigns commissions to an agency

Agent: Agent paid directly by Bravo Health



Contact information Sheet

Name : _____

Selling Market (please circle one or more): (TX - San Antonio, Houston, El Paso) - (PA – Philly, Pittsburgh) – (Mid Atlantic – MD, DC)-(New Jersey)

_____	_____	_____	
Last Name, first name, middle initial	Date of Birth	Social Security Number	
_____	_____	_____	
Business Address	City	State	Zip Code
()	()	_____	
Business Phone	Fax Number	E-mail Address	

Provider business office locations for last five years:

_____	_____	_____	_____	_____	_____
Business address	City	State	ZIP Code	From	To
_____	_____	_____	_____	_____	_____
Business address	City	State	ZIP Code	From	To
_____	_____	_____	_____	_____	_____
Business address	City	State	ZIP Code	From	To

Professional designation (i.e., CLU, RHU, LUTCF):

_____	_____	_____
Type of professional designation	From	To
_____	_____	_____
Type of professional designation	From	To
_____	_____	_____
Type of professional designation	From	To

List any insurance agency affiliations for the past five years:

_____	_____	_____	_____
Name of agency	City where agency is located	From	To
_____	_____	_____	_____
Name of agency	City where agency is located	From	To
_____	_____	_____	_____
Name of agency	City where agency is located	From	To



Bravo Health Contact Information
(continued)

Additional information:

If an answer to any of the following questions is "yes," attach details on separate sheet of paper.

	Yes	No
A. Has your license to sell insurance or HMO Products ever been denied, suspended or revoked by any state?	<input type="checkbox"/>	<input type="checkbox"/>
B. Have any complaints been filed against you with the State Department of Insurance or any other insurance regulatory board or agency within the last five years?	<input type="checkbox"/>	<input type="checkbox"/>
C. Have you ever been denied appointment or renewal appointment by any insurance and/or managed care company?	<input type="checkbox"/>	<input type="checkbox"/>
D. Have you ever been party to a lawsuit relating to the insurance or managed care industry?		
1. Have any settlements ever been made on your behalf?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are there any claims or cases presently filed or pending against you?	<input type="checkbox"/>	<input type="checkbox"/>
E. Have you ever filed for bankruptcy?	<input type="checkbox"/>	<input type="checkbox"/>
F. Have you ever been convicted of any criminal charge other than minor traffic offenses?	<input type="checkbox"/>	<input type="checkbox"/>
G. Are any legal actions pending against you by any employer, client, former associate, partner, state board of insurance, law enforcement agency or professional group or organization?	<input type="checkbox"/>	<input type="checkbox"/>
H. How long have you sold individual and/or group HMO products? _____		
I. How long have you been in the insurance business? _____		
J. Do you speak any foreign language? If yes, indicate language(s): _____		

I certify that the above statements are true and complete and no misrepresentations are contained with the application or attachments.

Signature

Date



Active appointments with insurance and/ or managed care companies:

	From	To	HMO		PPO		Life	
			Yes	No	Yes	No	Yes	No
_____ Company name	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____ Company name	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____ Company name	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____ Company name	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Authorization and release:

I understand that Bravo Health, Inc. will verify that information in this application and I hereby authorize Bravo Health, Inc. or its representatives to contact and obtain information references in this application from an individual present or former client, insurer, corporation or other business entity, regulatory or licensing agency, or state, city or federal agency.

By applying for appointment with Bravo Health, Inc., I extend absolute immunity to, and release and hold harmless from any and all liability: (i) Bravo Health, Inc., its representatives, employees, trustees, directors, and officers; (ii) any individual, present or former client, insurer, corporation, or other business entity, regulatory or licensing agency, or state, city or federal agency providing information, their representatives, employees, trustees, directors and officers; (iii) any third party for any acts, communications, reports, records, statements, documents, recommendations or disclosures involving me, requested or received by Bravo Health, Inc. and its representatives to, from, or by any third party, including otherwise privileged or confidential information.

I certify that the above statements are true and complete and no misrepresentations are contained within the application or attachments.

Name (please print)

Signature

Date

Application for appointment includes:

- Completed application, with signature on authorization and release above
- Copy of Current State License(s)

Return completed application along with required documents to:

Bravo Health, Inc.
Attn: Broker Sales Department
3601 O'Donnell Street
Baltimore, MD 21224

Bravo Health
Assignment of Commissions

To _____ Tax ID _____
(Legal entity that Commissions are being assigned to, hereinafter the "Assignee")

Assignee's Address _____

City _____ State _____ Zip Code _____

Telephone _____

For valuable consideration, the undersigned, herein called the Assignor, hereby assigns to the Assignee all of the Assignor's right, title, interest, claim or demand in and to any and all compensation now due and payable, or which may become due and payable, under existing contracts and agreements heretofore entered into by and between Bravo Health [Pennsylvania/Texas/Mid-Atlantic/California], Inc. (the "Company") and Assignor.

Assignor hereby authorizes and empowers the Company to pay Assignee all compensation (including but not limited to over-riding commissions) now due or which may become due under the Agreement until such time as Assignor terminates this assignment by written notice to the Company. Assignor acknowledges and agrees that such payment of compensation to Assignee shall constitute payment of such compensation to the Assignor as if paid directly to the Assignor and the Company shall be fully released from any and all responsibility to the Assignor for such payments. Assignor hereby acknowledges and agrees that assignment of compensation payable under the agreement does not release or otherwise relieve Assignor of any obligation or responsibility under the Agreement including, but not limited to, the obligation to pay commissions to any applicable "downline" sales hierarchy and/or the obligation to reimburse the Company for compensation paid on premiums subsequently refunded.

Assignor hereby covenants and agrees that Assignor is the absolute and sole owner of said compensation, free from assignment or encumbrance of any kind or character whatsoever, and has full right and lawful authority to so assign same. The Assignor shall at all times defend, indemnify and hold harmless the Company and its officers, agents, and employees from and against any and all suits, actions, losses, damages, claims, expenses (including but not limited to the Company's legal expenses) and liability of any character, type or description arising out of the execution or performance

of this assignment.

Assignor Signature _____ Dated _____

Assignor Name _____
(Print)

Assignee Signature _____ Dated _____

The Company acknowledges receipt of, and consents to the foregoing assignment, but assumes no responsibility for the validity or sufficiency hereof. This assignment is effective on the date signed by an authorized representative of the company.

By _____ Dated _____
(Authorized Company Signature)

Company Representative Name _____ Title _____

(Print)

Policy and Procedure Sign-Off Sheet

By signing this, I _____ confirm that I have received Bravo Health's corporate Sales policies and procedures. I also attest that I have read them completely and thoroughly, understand them to the fullest extent, and agree to abide by the guidelines they establish. If at any time I am unclear about a policy or have a question I will consult my Sales Manager / Sales Lead for further guidance.

Career Representative / Agent / Broker

Date

Sales Manager / Sales Lead

Date

Agent Agreement

This Agent Agreement (the "Agreement"), effective _____, 20____ (the "Effective Date"), is made by and between [**Bravo Health Pennsylvania, Inc./Bravo Health Texas, Inc./Bravo Health Mid-Atlantic, Inc./Bravo Health Insurance Company, Inc./Bravo Health California, Inc.**] ("Bravo Health") and _____ ("Agent").

WHEREAS, Bravo Health is contracted with the Centers for Medicare and Medicaid Services ("CMS") to offer Medicare Advantage benefit plans (collectively, the "Plans") to Eligible Medicare Beneficiaries (as defined below);

WHEREAS, Bravo Health desires to secure the services of Agent to facilitate the enrollment of Eligible Medicare Beneficiaries into its Plans and to compensate Agent therefore, as more explicitly described herein;

WHEREAS, Agent has agreed to provide such services subject to the terms and conditions of this Agreement; and

NOW, THEREFORE, in consideration of the mutual covenants and agreements set forth in this Agreement and other good and valuable consideration, the parties hereto intending to be legally bound, hereby agree as follows:

SECTION 1 Definitions

1.1 **CMS.** The Centers for Medicare and Medicaid Services, which is the federal agency within the United States Department of Health and Human Services that administers the Medicare and Medicaid programs.

1.2 **Commissions.** The payments due Agent for the services performed by Agent under this Agreement. The Agent's Commissions shall be calculated and paid as provided for in Exhibit A, the Bravo Health Commission Payment Policy.

1.3 **Contract Month and Contract Year.** The calendar month or year as determined from the effective date of the Eligible Medicare Beneficiary's enrollment into the Plans.

1.4 **Service Area.** The geographic area in which Bravo Health is authorized to offer the Plans and in which Agent is licensed to and may solicit enrollment of Eligible Medicare Beneficiaries under this Agreement.

1.5 **Eligible Medicare Beneficiary.** A Medicare eligible individual, excluding Medicare eligible individuals who seek to enroll in a stand alone Part D Medicare Prescription Drug Plan, solicited under this Agreement who:

- a. is located in the Service Area;
- b. is eligible to receive Medicare or Medicare/Medicaid benefits; and
- c. is approved by Bravo Health and CMS and is accepted for enrollment under a Medicare Advantage Plan issued by Bravo Health.

1.6 **Agent Code of Ethics.** Agent agrees to adhere to Bravo Health's Agent Code of Ethics when acting on behalf of or representing Bravo Health at any time; such code is attached hereto and incorporated herein as Exhibit B of this Agreement. Violation of the Code of Ethics shall be deemed a material breach of this Agreement and shall be considered termination for cause under the terms of this Agreement.

proposed by Bravo Health, shall be effective thirty (30) days after Bravo Health has given written notice to Agent of the amendment, and Agent has failed, within fifteen (15) days of Agent receiving written notice, to notify Bravo Health in writing of Agent's rejection of the requested amendment. Amendments required because of legislative, regulatory or legal requirements do not require the consent of Agent or Bravo Health and will be effective immediately on the effective date thereof. Any amendment to this Agreement requiring prior approval of or notice to any federal or State regulatory agency shall not become effective until all necessary approvals have been granted or all required notice periods have expired.

9.3 Assignment. Bravo Health may assign all or any of its rights and responsibilities under this Agreement to any entity controlling, controlled by, or under common control with Bravo Health. Agent acknowledges that persons and entities under contract with Bravo Health may perform certain administrative services under this Agreement. Agent may not assign any of its rights, responsibilities or Commissions payable under this Agreement to any unrelated person or entity without the prior written consent of Bravo Health.

9.4 Non-Solicitation. Throughout the term of this Agreement and for a period of eighteen (18) months thereafter, Agent shall not, without Bravo Health prior written consent, directly or indirectly engage in the Solicitation, as defined below, of any Eligible Medicare Beneficiary. For the purposes of this Section "Solicitation" shall mean any oral or written statement or other action by Agent or by Agent's agents that may be reasonably interpreted to be intended to persuade any Eligible Medicare Beneficiary to disenroll from Bravo Health, enroll in another Medicare Advantage or PDP plan, or enroll in any other health plan, including traditional Medicare. Notwithstanding any other provision to the contrary, Bravo Health shall, in addition to any other remedies provided for under this Agreement, have the right to seek a judicial temporary restraining order, preliminary injunction, or other equitable relief against Agent to enforce its rights under this Section.

9.5 Notices. Any notice required or desired to be given under this Agreement shall be in writing and shall be sent by certified mail, return receipt requested, postage prepaid, or overnight courier, addressed as follows:

To Bravo Health: Bravo Health, Inc.
3601 O'Donnell Street
Baltimore, MD 21224
Attn.: Executive Vice President, Sales

With copy to: Legal Department, General Counsel
Bravo Health, Inc.
3601 O'Donnell Street
Baltimore, MD 21224

To Agent:

Attn.: _____

9.6 Governing Law. This Agreement shall be governed by, and construed, and enforced in accordance with the laws of the State under which Agent and Bravo Health are licensed and in which Agent is soliciting Eligible Medicare Beneficiaries, except to the extent such laws conflict with or are preempted by any federal law, in which case such federal law shall govern.

9.7 Non Exclusive Contract. The Agreement is non-exclusive and shall not prohibit Agent or Bravo Health from entering into agreements with other such entities.

9.8 No Third Party Beneficiaries. Nothing in this Agreement is intended to, or shall be deemed or construed to create any rights or remedies in any third party, including an Eligible Medicare Beneficiary. Nothing contained herein shall operate (or be construed to operate) in any manner whatsoever to increase the rights of any such Member or the duties or responsibilities of Agent or Bravo Health with respect to such Members.

9.9 Instructions and Communications. From time to time, Bravo Health shall use newsletters, letters, and similar written forms of communication to inform Agents of changes to Bravo Health policies and procedures that may affect Agent. Bravo Health shall use best efforts to provide reasonable advance notification of at least thirty (30) days when there are planned changes in such policies and procedures that can be expected to have a material effect on Agent. Agent agrees to comply with such communications.

9.10 Severability. If any provision of this Agreement is rendered invalid or unenforceable by any local, State, or federal law, rules or regulations, or declared null and void by any court of competent jurisdiction, the remainder of this Agreement shall remain in full force and effect.

9.11 Status as Independent Entities. None of the provisions of this Agreement are intended to create, nor shall be deemed or construed to create, any relationship between Agent and Bravo Health other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement. Neither Agent nor Bravo Health, nor any of their respective agents, employees, or representatives shall be construed to be the agent, employee or representative of the other.

9.12 Exhibits, Attachments and Amendments. Each Exhibit, Attachment and Amendment to this Agreement is made part of this Agreement as though set forth fully herein. Any provision of an Exhibit, Attachment or an Amendment that is in conflict with any provision of this Agreement shall take precedence and supersede the conflicting provision of this Agreement.

9.13 Waiver. The waiver by either party of a breach or violation of any provision of this Agreement shall not be deemed effective unless made in writing, and no such waiver shall be deemed a waiver of any other breach of the same or a different provision.

9.14 Entire Agreement. This Agreement, together with the Exhibits and all other documents incorporated by reference, contains all the terms and conditions agreed upon by the parties hereto regarding the subject matter of this Agreement. Any prior or contemporaneous agreements, promises, negotiations or representations, either oral or written, relating to the subject matter of this Agreement not expressly set forth in this Agreement are of no force or effect. Neither Party shall be entitled to any benefits other than those specified herein. The Parties acknowledge that in entering into and executing this Agreement, the Parties rely solely upon the representations and agreements contained in this Agreement and no others.

9.15 Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, and said counterparts shall constitute but one in the same instrument.

IN WITNESS WHEREOF, the parties have executed this Agreement to be effective as of the Effective Date.

AGENT

BRAVO HEALTH

Signature

Print Name

Title

Date

Federal Tax Identification Number

Signature

Print Name

Title

Date

inaccurate, materially mislead, confuse Medicare beneficiaries, or misrepresent Bravo Health or its benefit plans).

I have read and will comply with the Code of Ethics listed above.

Signature of Agent

EXHIBIT C

HIPAA BUSINESS ASSOCIATE ADDENDUM AGREEMENT

This HIPAA Business Associate Addendum Agreement (“Addendum”) amends and is made part of the underlying Agent Agreement (the “Agreement”) by and between _____ (hereinafter referred to as “Business Associate”) and Bravo Health, Inc. on behalf of itself and its affiliates and subsidiaries (collectively “Bravo Health”) and is effective as of the Effective Date of the Agreement.

In the performance of services on behalf of Bravo Health pursuant to the Agreement, and in order to disclose certain information to Business Associate pursuant to the terms of the Agreement, some of which may constitute Protected Health Information (“PHI”) (defined below), _____ is a Business Associate of Bravo Health as that term is defined by the Health Insurance Portability and Accountability Act of 1996 and its implementing Administrative Simplification regulations (45 CFR parts 160, 162 and 164) (“HIPAA Rules”). Bravo Health and Business Associate may also be subject to the provisions of the HITECH Act portions of the American Recovery and Reinvestment Act of 2009 (“ARRA”) and the implementing regulations promulgated by the Secretary of the U.S. Department of Health and Human Services (“HHS”) in conjunction with the HIPAA Rules.

To the extent that any provision(s) of this Addendum conflict(s) with provision(s) contained in the Agreement, the provision(s) in this Addendum shall control with respect to the use and disclosure of PHI.

1. Definitions

1.1 “Protected Health Information” shall mean information created or received by a health care provider, health plan, employer or health care clearinghouse, that: (i) relates to the past, present, or future physical or mental health or condition of an individual, provision of health care to the individual, or the past, present or future payment for provision of health care to the individual; (ii) identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual; and (iii) is transmitted or maintained in an electronic medium, or in any other form or medium.

1.2 “Standard Transaction(s)” shall mean a transaction that complies with the standards set forth at 45 CFR parts 160 and 162.

1.3 All other terms used in this Addendum shall have the meanings set forth in the applicable definitions under the HIPAA Rules.

2. Privacy of Protected Health Information

2.1. Permitted Uses and Disclosures. Business Associate agrees to use or disclose PHI only as follows:

- a. Functions and Activities on Bravo Health’s Behalf. Business Associate is permitted to use and disclose PHI it creates or receives in connection with services to be provided under the Agreement only as permitted by the Agreement.
- b. Business Associate’s Operations – Use of PHI. Business Associate is permitted by

PHI.

8.13 Notices. All notices and notifications under this Addendum shall be sent in accordance with the Notice section of the Agreement.

8.14 Complaints. If Business Associate receives a complaint concerning Business Associate's activities pursuant to this Addendum or concerning Bravo Health's privacy practices, Business Associate will forward this complaint to the Bravo Health Privacy Officer promptly upon receipt, using a method that is likely to ensure delivery to the Bravo Health Privacy Officer within five (5) business days of receipt by Business Associate (e.g., fax, e-mail, express mail, hand delivery).

8.15 Documentation. All documentation that is required by this Addendum or by the HIPAA Rules must be retained by Business Associate for ten (10) years from the date of creation or when it was last in effect, whichever is longer.

8.16 State Law. Where the mandatory terms of the HIPAA Rules or this Addendum conflict with obligations imposed under *state law* (as defined in the HIPAA Rules) relating to the privacy of individually identifiable health information and state law is *more stringent* (as defined in the HIPAA Rules) than this Addendum or the Privacy Rule, Business Associate shall follow the state law with regard to the proper uses and disclosures of PHI. However, prior to taking any action in furtherance of a state law that Business Associate has interpreted is contrary to and more stringent than this Addendum or the Privacy Rule, Business Associate shall notify Bravo Health in writing of its interpretation. If Bravo Health disagrees with the Business Associate's interpretation and believes either that Business Associate is able to comply with state law and this Addendum (and the HIPAA Rules), or that the HIPAA Rules (and not state law) controls the use and disclosure of protected health information, then Bravo Health's interpretation shall prevail with respect to the creation, receipt, use or disclosure of PHI in connection with the services provided by Business Associate to Bravo Health under the Agreement. Bravo Health shall indemnify and hold harmless Business Associate consistent with Section 6.1 herein against any claims or regulatory action which may arise due to Business Associate's compliance with Bravo Health's interpretation of state law with respect to the creation, receipt, use or disclosure of PHI in connection with the services provided by Business Associate to Bravo Health under the Agreement.

IN WITNESS WHEREOF, Bravo Health and Business Associate execute this Addendum in multiple originals to be effective as of the Effective Date.

Business Associate

Bravo Health

By:

By:

Signature: _____

Signature: _____

Title: _____

Title: _____

Date: _____

Date: _____

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, if different from above	
	Check appropriate box: <input type="checkbox"/> Individual/ Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other ▶	
	<input type="checkbox"/> Exempt from backup withholding	
	Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
	City, state, and ZIP code	
List account number(s) here (optional)		

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 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.

Social security number								

OR

Employer identification number								

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

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).

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 ▶
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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.

U.S. person. 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.

In 3 above, 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.

For federal tax purposes, you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

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.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

- The U.S. grantor or other owner of a grantor trust and not the trust, and
- The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien.

Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments (after December 31, 2002). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 4 for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Also see *Special rules regarding partnerships* on page 1.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line. Check the appropriate box for your filing status (sole proprietor, corporation, etc.), then check the box for "Other" and enter "LLC" in the space provided.

Other entities. Enter your business name as shown on required federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Note. You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

Exempt From Backup Withholding

If you are exempt, enter your name as described above and check the appropriate box for your status, then check the "Exempt from backup withholding" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

Exempt payees. Backup withholding is not required on any payments made to the following payees:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),
 2. The United States or any of its agencies or instrumentalities,
 3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,
 4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or
 5. An international organization or any of its agencies or instrumentalities.
- Other payees that may be exempt from backup withholding include:
6. A corporation,
 7. A foreign central bank of issue,
 8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,
 9. A futures commission merchant registered with the Commodity Futures Trading Commission,
 10. A real estate investment trust,
 11. An entity registered at all times during the tax year under the Investment Company Act of 1940,
 12. A common trust fund operated by a bank under section 584(a),
 13. A financial institution,
 14. A middleman known in the investment community as a nominee or custodian, or
 15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt recipients listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt recipients except for 9
Broker transactions	Exempt recipients 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt recipients 1 through 5
Payments over \$600 required to be reported and direct sales over \$5,000 ¹	Generally, exempt recipients 1 through 7 ²

¹ See Form 1099-MISC, Miscellaneous Income, and its instructions.

² However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees; and payments for services paid by a federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-owner LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter your SSN (or EIN, if you have one). If the LLC is a corporation, partnership, etc., enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at www.socialsecurity.gov. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at www.irs.gov/businesses and clicking on Employer ID Numbers under Related Topics. You can get Forms W-7 and SS-4 from the IRS by visiting www.irs.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Writing "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt recipients, see *Exempt From Backup Withholding* on page 2.

Signature requirements. Complete the certification as indicated in 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account ¹
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor ²
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee ¹
b. So-called trust account that is not a legal or valid trust under state law	The actual owner ¹
5. Sole proprietorship or single-owner LLC	The owner ³
For this type of account:	Give name and EIN of:
6. Sole proprietorship or single-owner LLC	The owner ³
7. A valid trust, estate, or pension trust	Legal entity ⁴
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

¹ List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

² Circle the minor's name and furnish the minor's SSN.

³ You must show your individual name and you may also enter your business or "DBA" name on the second name line. You may use either your SSN or EIN (if you have one). If you are a sole proprietor, IRS encourages you to use your SSN.

⁴ List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules regarding partnerships* on page 1.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. possessions to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.