

Arise Health Plan Contracting

Arise Health Plan Contracting - Thanks for looking at our Opportunity to become an Independent Contractor with Affordable Health Insurance Agency, LLC. It was a pleasure talking with you! Here is all the paperwork needed for contracting with us. If you have any questions, feel free to call us at 888-883-8490 or 262-784-7344.

- Print off and Fill out this paper work with Black Pen, print and write legible.
- Please Fax or mail me a copy of your State License (WI ONLY) that you wish to be appointed in and a Copy of your Errors and Omissions Insurance (E & O). If you do not have E & O, this is something that you will need to obtain. This Carrier will NOT let you contract if you do NOT have E & O coverage. Ask me about your E & O options. We currently have a company that provides E & O coverage for the year and runs about \$400/year.
- Fax to 262-821-0508 Attn: Vicky
- If you do not have a fax then mail to:

Affordable Health Insurance Agency, LLC
Attn: Vicky
17100 W. Bluemound Road Ste 202
Brookfield, WI 53005

- Any questions feel free to call or email me sales@etruehealth.com.

NOTE: The Last FORM on this application is a form we need filled out by you so your Commissions will be direct Deposited into your Checking Account. Please attach a voided Check!

BUSINESS ASSOCIATE AGREEMENT

This agreement ("Agreement") is effective upon execution by and between _____
("Business Associate") and WPS Health Plan, Inc. ("Company"). *Agent Name*

Company and Business Associate mutually agree to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. Parts 160-64).

A. Privacy of Protected Health Information.

1. Permitted Uses and Disclosures. Business Associate is permitted or required to use or disclose Protected Health Information it creates or receives for or from Company or to request Protected Health Information on Company's behalf only as follows:

a) Functions and Activities on Company's Behalf. Except as otherwise limited in this Agreement, Business Associate is permitted to request the minimum necessary protected health information on Company's behalf, and to use and to disclose the minimum necessary Protected Health Information to perform _____ functions, activities, or services for or on behalf of Company.

b) Business Associate's Operations. Business Associate may use the minimum necessary Protected Health Information for Business Associate's proper management and administration or to carry out Business Associate's legal responsibilities. Business Associate may disclose the minimum necessary Protected Health Information for Business Associate's proper management and administration or to carry out Business Associate's legal responsibilities only if:

- (i) The disclosure is required by law; or
- (ii) Business Associate obtains reasonable assurance, evidenced by written contract, from any person or organization to which Business Associate will disclose Protected Health Information that the person or organization will:
 - a. Hold such Protected Health Information in confidence and use or further disclose it only for the purpose for which Business Associate disclosed it to the person or organization or as required by law; and
 - b. Promptly notify Business Associate (who will in turn promptly notify Company) of any instance of which the person or organization becomes aware in which the confidentiality of such Protected Health Information was breached.

2. Prohibition on Unauthorized Use or Disclosure. Business Associate will neither use nor disclose Protected Health Information except as permitted or required by this Agreement, as otherwise permitted in writing by Company, or as required by law. This Agreement does not authorize Business Associate to use or disclose Protected Health Information in a manner that would violate the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. Parts 160-64) if done by Company, except as set forth in Section A(1)(b).

3. Information Safeguards.

a) Privacy of Company's Protected Health Information. Business Associate will develop, implement, maintain, and use appropriate administrative, technical, and physical safeguards, in compliance with Social Security Act § 1173(d) (42 U.S.C. § 1320d-2(d)), 45 Code of Federal Regulations § 164.530(c) and any other implementing regulations issued by the U.S. Department of Health and Human Services. The safeguards will be designed to preserve the integrity and confidentiality of, and to prevent intentional or unintentional non-permitted or violating use or

professionals to represent its interests, in which case Business Associate will be responsible for and pay the reasonable fees and expenses of such attorneys, consultants, and other professionals.

b) Right to Control Resolution. Company will have the sole right and discretion to settle, compromise or otherwise resolve any and all claims, causes of actions, liabilities or damages against it, notwithstanding that Company may have tendered its defense to Business Associate. Any such resolution will not relieve Business Associate of its obligation to indemnify Company under Section D.3.

E. General Provisions.

1. Definitions. The capitalized term "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 C.F.R. § 164.501, limited to the information created or received by Business Associate from or on behalf of Company or another business associate of Company. The capitalized term "Standard Transactions" shall have the meaning set out in, 45 C.F.R. § 162.103.

2. Amendment to Agreement. Upon the effective date of any final regulation or amendment to final regulations promulgated by the U.S. Department of Health and Human Services with respect to Protected Health Information or Standard Transactions, this Agreement will automatically amend such that the obligations they impose on Business Associate remain in compliance with these regulations.

IN WITNESS WHEREOF, Company and Business Associate execute this Agreement in multiple originals to be effective on the last date written below.

Business Associate:

WPS Health Plan, Inc.

By: X _____

By: _____

Its: _____

Its: Chief Operating Officer

Date: _____

Date: _____

PRODUCER AGREEMENT
WPS Health Plan, Inc

This Agreement is made as of the _____ day of _____, by and between WPS Health Plan, Inc. (d/b/a Arise Health Plan), herein referred to as WPSHP, and

Name: _____ State License Number: _____

Social Security Number: _____ E Mail: _____

Mailing Address: _____

City, State, Zip Code: _____

herein referred to as Producer.

Section 1 Authorization

- 1.1 The Producer is authorized, subject to the terms, conditions, and provisions of this Agreement, to solicit new insurance applications for WPSHP and to assist and support WPSHP in the renewal and service of WPSHP insured business recorded to the Producer. Such authority shall only apply to the extent legally permissible for the Producer under the laws, licensing requirements and applicable rules of the regulatory authorities of the jurisdiction in which the Producer operates. WPSHP reserves the right, at any time, to service any applicant or policyholder account to the extent that WPSHP deems necessary.

- 1.2 The Producer is an independent contractor with respect to its services, duties, and obligations hereunder. Nothing contained herein shall be construed to create the relationship of employer and employee between WPSHP and the Producer or between WPSHP and any of the Producer's employees or subagents. The authority of the Producer under this Agreement shall not extend to or affect the general practices and administrative policies of WPSHP.

- 1.3 The Producer may select and contract with properly-licensed subagents to aid in the Producer's business and to assist the Producer in representing WPSHP in accordance with the terms, conditions, and provisions of this Agreement, provided each subagent is first listed with WPSHP through the Wisconsin Office of the Commissioner of Insurance, herein referred to as OCI, to the extent required by law. WPSHP, however, reserves the right at all times, and in its sole discretion, to refuse to allow any such subagent to assist the Producer in presenting WPSHP. All contracts with such subagents shall be made directly with the Producer. WPSHP is not a party to those contracts, nor is WPSHP liable or responsible in any way under those contracts. The Producer shall be solely responsible to any subagents or employees of the Producer for their total

IN WITNESS THEREOF, this Agreement has been executed by the parties' duly authorized representatives.

Producer

WPS Health Plan, Inc.

Signature: X_____

Signature: _____

Name (Please Print): _____

Name (Please Print): _____

Title: _____

Title: Chief Operating Officer

Date: _____

Date: _____

PRODUCER ASSIGNMENT OF COMMISSIONS

This Producer's Assignment of Commissions is executed in conjunction with the execution of the Producer Agreement between WPS Health Plan, Inc., and _____, hereinafter referred to the Producer, effective as of the date shown below.

I agree to assign all commissions to the following entity to be paid according to the contract and Producer Agreement Commission Schedule:

Corporate Legal Name: Liberty Insurance Group, Inc

DBA Name: SAME

Tax ID#: 39-1975208

Business Address: 17100 W. Bluemond Rd. Ste 202, Brookfield WI 53005
Street City State Zip

Mailing Address: Same
Street City State Zip

Business Phone #: 262-785-1021 Fax #: 262-821-0508

State License #: 2351424

IN WITNESS WHEREOF, the Producer executed this Producer's Assignment of Commissions this ___ day of _____, 200__.

Signature: X

Name (Please Print): _____

Affordable Health Insurance Agency, LLC.

Kevin Truebenbach

Specialist In Health/Life Insurance, Critical Illness, Medicare Supplements, & Long Term Care



Direct Deposit Instructions

Fill out these 2 pages (use this as fax cover sheet) Fax to 262-821-0508 Attn: Vicky

Agent Info Sheet Please fill out:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Full Social Security or TAX ID: _____

Email address for commission statements: _____

Must Attach a voided Check for the account you want the money to be deposited in. The name on the account must match the name on the Paychex form, then sign & date.

If you have a business name on the Check, you must fill out the form with your Business name. This is the only way Paychex can confirm the account.

Example: ABC Insurance Agency is on the check, you would put this name on the Paychex form under the "worker name". A deposit form does NOT work, must be check.

If you want money to be deposited into a Savings account you will need to get a letter from the bank with the Routing and Account Number. Attach that with this form!

All Commissions over \$100 dollars will be Direct Deposited NO LATER THEN the 11th of each month. If your commissions are below \$100 dollars, that money will be carried over for the next month.

My goal is to have the money into your Account on the 11th of Each Month. **Your Statement will be emailed to you by the 11th.** So please include what email address above where to send your statements. Common sense, if the 11th falls on a Saturday or Sunday. The money will be deposited within the next 2 business days.

Any Questions feel free to call or email me at sales@etruehealth.com

Happy Selling!

Thanks,

Kevin Truebenbach

Paychex Use Only	
Client Account Number _____	Date _____
Worker Number _____	Title _____
PRS _____	Contact _____
Verified By _____	CSS Initials _____

Scanning instructions are located in Paychex Procedures.

PAYCHEX

Direct Deposit Signup Form

Worker Instructions:

1. Complete the "WORKER - Required Information" section.
2. Complete the Direct Deposit section to specify where you want your pay deposited.
3. Sign the bottom of the form.
4. Retain a copy of this form for your records. Return the original to your employer.

Employer Instructions:

1. Complete the "EMPLOYER - Required Information" section.
2. Return this form to your local Paychex office.*
*See below for acceptable bank documentation.

WORKER - Required Information

PLEASE PRINT

Worker Name _____

Last four digits of Social Security Number _____

EMPLOYER - Required Information

PLEASE PRINT

Company Name Affordable Health Ins. Agency, LLC

Service Location/Client Acct. Number C342

Federal ID Number 20-2688785

Complete for Direct Deposit and Sign Below

I authorize my employer to deposit my wages/salary to the following bank account(s):

Bank Account #1

Checking
Bank Name _____

Savings
Bank Name _____

Chase Pay Card Plus
Please complete the attached application if you would like to sign up for Chase Pay Card Plus.

I wish to deposit (check one):

Remainder of Net Pay

_____ % of Net

Specific Dollar Amount \$ _____ .00

Please attach one of the following for Checking or Savings accounts (check one):

Voided check

Deposit slip (only accepted if the verbiage "ACH R/T" appears before the routing number)

Bank letter or specification sheet (the signature of your local bank representative MUST be included)

Bank Account #2

Checking
Bank Name _____

Savings
Bank Name _____

Chase Pay Card Plus
Please complete the attached application if you would like to sign up for Chase Pay Card Plus.

I wish to deposit (check one):

Remainder of Net Pay

_____ % of Net

Specific Dollar Amount \$ _____ .00

Please attach one of the following for Checking or Savings accounts (check one):

Voided check

Deposit slip (only accepted if the verbiage "ACH R/T" appears before the routing number)

Bank letter or specification sheet (the signature of your local bank representative MUST be included)

Employer Section Only

If bank documentation provided is different from what is listed above, the following must be completed by the employer:

I confirm that the above named employee has added or changed a bank account for direct deposit transactions processed by Paychex, Inc.

Employer Signature _____

Worker Signature _____ Date ____/____/____

By signing above, I am agreeing that I am either the accountholder or have the authority of the accountholder to authorize my employer to make direct deposits into the named account.

Accountholder Signature _____
(If worker doesn't have authority to authorize deposits to the accountholder's account.)

Sign By 'X' & Attach Voided Check Please!