Hierarchy Form

Agent Name _____

GA Name _____

MGA Name _____

SGA Name _____

FMO Name National Contracting Center

Please check ONE

Agent assigns commissions to an agency
Agent paid directly by HealthSpring

Agent Signature_____

Date_____

Cigna HealthSpring

Contact information

All information is required to complete contracting

☐ **Please Check if you will be conducting Telephonic Enrollments**

Last Name, first name, middle initial | Date of Birth | Social Security Number

Address | City | State | Zip Code

Business Phone | Cell Phone | Fax Number | E-mail Address

Please list all websites and/or website affiliations:

Provider business office locations for last five years:

Ex: 10/12

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:

Ex. 10/12

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

Please indicate the service area(s) in which you plan to sell HealthSpring (please select all that apply):
(You MUST have a currently active state Health license in all of the states for the service areas you selected below)

☐ **Alabama**	☐ **Florida**	☐ **Mississippi**	☐ **Tennessee**
☐ **Arizona**	☐ **Georgia**	☐ **N. Carolina**	☐ **Texas**
☐ **Arkansas**	☐ **Illinois**	☐ **Oklahoma**	
☐ **D.C.**	☐ **Indiana**	☐ **Pennsylvania**	
☐ **Delaware**	☐ **Maryland**	☐ **S. Carolina**	

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?	☐	☐
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?	☐	☐
C. Have you ever been denied appointment or renewal appointment by any insurance and/or managed care company?	☐	☐
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?	☐	☐
2. Are there any claims or cases presently filed or pending against you?	☐	☐
E. Have you ever filed for bankruptcy?	☐	☐
F. Have you ever been convicted or are you currently being charged or under investigation for any violation of the law other than minor traffic violations?	☐	☐
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?	☐	☐
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:

Company Name _____	From	To
Company Name _____	From	To
Company Name _____	From	To
Company Name _____	From	To

Authorization and release:

I understand that Cigna-HealthSpring Inc. will verify that the information in this application is correct and I hereby authorize Cigna-HealthSpring 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 Cigna-HealthSpring Inc., I extend absolute immunity to, and release and hold harmless from any and all liability: (i) Cigna-HealthSpring 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 Cigna-HealthSpring 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:

Corporate Contracting
Contracting.mailbox@healthspring.com
Attn: Corporate Sales Operations
500 Great Circle Rd
Nashville TN 37228

Cigna HealthSpring

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.

You may also be asked to adhere to a random drug test at which HealthSpring has the right to initiate, subject to state notification provisions.

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 ☐ *Please check the box that applies*

Date: _____ *Signature of Applicant:* _____

Print Name: _____

Form **W-9**
(Rev September 2007)
Department of the Treasury
Internal Revenue Service

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: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership
☐ Limited liability company Enter the tax classification (D=disregarded entity C=corporation P=partnership) ▶
☐ Other (see instructions) ▶

☐ Exempt payee

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.

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

or

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.

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,

Electronic Payment (ACH) Authorization Agreement

I hereby authorize _____to deposit any amounts owed me by initiating credit entries to the bank account listed below in the amounts specified Also, I authorize _____the right to correct any Electronic Funds Transfer resulting from an erroneous overpayment by debiting my account for an amount not to exceed the original amount of the erroneous credit This authorization is to remain in force until the company receives written notice from me of its termination in such time and in such manner as to afford the company a reasonable opportunity to act on it.

Vendor Information

Name (please print): _____

Social Security Number: ☐☐☐-☐☐-☐☐☐☐

OR

Tax ID Number: ☐☐-☐☐☐☐☐☐☐

Address: _____

Check One: ☐ Checking ☐ Savings

Requested Start Date for ACH:_____
Ex: 11/22/12

Check One: ☐ New ☐ Change ☐ Stop

Bank Routing #: ☐☐☐☐☐☐☐☐☐ Bank Account #:

******MUST ATTACH A COPY OF A VOIDED CHECK******

Signature _____ Date _____

FINANCE USE ONLY	
RECEIVED:	PS VENDOR #:
ENTERED INTO PEOPLESOFT:	

All Cigna-HealthSpring agents are contractually obligated to read, review, and abide by all Cigna-HealthSpring policies and procedures All policies and procedures can be found on the Cigna-HealthSpring OMT site at:

Browser Address:
https://omt.gormanhealthgroup.com/DocLib/Default.aspx?FileObjectID=99173&ParentFileObjectID=19212&Paging=0

Your login name is **sales.agent@HealthSpring.com**

Your password is **HealthSpring2**

By signing this, Acknowledgement Form I, _____confirm that I have received Cigna-HealthSpring corporate Sales policies and procedures and will abide by all of the requirements set forth above. 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.

_____ _____

Employed/Contracted Agent Date

- Agree to adhere to Cigna-HealthSpring sales performance and disciplinary standards as set forth in Cigna-HealthSpring policies and procedures, herein incorporated by reference.

- Have an executed HIPAA Agreement for Agents affiliated with an Agency, or have a Business Associate Agreement for Agents directly contracted with Cigna-HealthSpring.

☐ **Errors and Omissions**

Subordinate Broker or Agent shall provide evidence to Cigna-HealthSpring that such coverage is in force prior to the execution hereof, and from time to time upon Cigna-HealthSpring's request. Subordinate Broker or Agent shall notify Cigna-HealthSpring immediately if such insurance is or will be reduced, modified, canceled or terminated Subordinate Brokers or Agents, shall maintain Errors and Omissions Insurance in amounts consistent with industry standards, but at no time less than $250,000 per occurrence and $250,000 aggregate limit, with a reasonable deductible, or the applicable state required coverage amounts, and to provide evidence of such coverage upon request by Cigna-HealthSpring.

☐ **Individual Leads**

Cigna-HealthSpring is not responsible for supporting the Subordinate Broker or Agent with leads or financial support in their prospecting efforts. During a visit with the prospect, Subordinate Broker or Agent can present the Cigna-HealthSpring Medicare Advantage products with full disclosure and enroll the prospect. Referrals may only be sought in accordance with Cigna-HealthSpring policy and applicable CMS guidelines. Subordinate Brokers or Agents must follow all guidelines and regulations that govern the proper procedure for prospecting, and selling, the Cigna-HealthSpring product including all requirements set forth under MIPPA and the CMS Medicare Marketing Guidelines.

☐ **Commissions – Individual Sales**

Enrollments must be a result of the direct contact between the FMO or Subordinate SGA, Broker or Agent and the individual prospect. Cigna-HealthSpring will pay a commission for each individual whom FMO or Subordinate SGA, Brokers or Agents enroll in a Cigna-HealthSpring Medicare Advantage Plan. Commissions are paid per the current commission schedule set forth in Exhibit A. The allocated portion of the commission payments will be paid directly to the FMO and Agent of Record during the normal commission payment schedule as set forth by Cigna-HealthSpring policy unless otherwise agreed between the parties

By: _____

Print Name: _____

Date: _____

EXHIBIT A
MEDICARE ADVANTAGE SCHEDULE OF COMMISSIONS

As companies reserve the right to modify their contracts at any point, we ask you to allow National Contracting Center to affix your signature to any pages of a contract a company may have changed or that you may have overlooked as long as clear consent has been given via phone or email.

I, _____, hereby authorize National Contracting Center to affix or append a facsimile of my signature, as set forth below, to all required signature fields on any updated or overlooked paperwork for the purposes of being contracted to sell products for the company(s) of my interest through their Contracting Department.

I affirm that the information that I have submitted in my contracts is correct to the best of my knowledge and acknowledge that I have read, reviewed, and agreed to the documents for which I am authorizing my signature to be affixed. I acknowledge and agree to indemnify and hold harmless any third party from and against any loss arising out of its reliance and acceptance of a facsimile of my signature.

Please read, sign, and fax back to 1-865-777-2958

Please sign in the middle of the below box.