HEALTHPRO CONSULTANTS

CONTRACTING WITH HEALTHPRO CONSULTANTS

Welcome to HealthPro Consultants!

To get started, please fill out the forms included with this cover page and fax, or send using a secure email, back to us with these additional documents:

- Copy of your insurance license
- Copy of your E&O (if you carry it)
- Copy of a voided check for direct deposit
- Copy of proof of anti-money laundering training
- Copy of written explanation for any background issues (outlined on the Background Information page)
- Copy of CE training certificate (if required in your state)
- If applying as principal of a corporation, please provide a corporate license and voided check in addition to your individual license.
- If applying for Athene and are a corporation, please provide corporate resolution, or list of authorized signers
- Please be advised that some carriers charge resident and-or non-resident appointment fees. Contact HealthPro Consultants for details.

If you have any questions, please call 1 (216) 236-1466 for assistance.

We look Forward to Partnering with you!

REGISTRATION ON WWW.HEALTHPROCONSULTANTS.COM IS REQUIRED TO PROCESS CONTRACTING

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CONTRACT APPLICATION

Agent Name: _____ SSN: _____ - _____ - _____

Agency Name (if applicable): _____ Tax ID: _____ - _____

Personal Name or Principal: _____

Insurance License Number: _____ Birth Date (MM/DD/YYYY) _____/_____/_____

NPN Number: _____ ☐ Male ☐ Female

Agent Home Address: _____

City: _____ State: _____ ZIP: _____ County: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____ County: _____

UPS Street Address: _____

City: _____ State: _____ ZIP: _____ County: _____

Phone Res: _____ Business: _____

Fax: _____ Mobile: _____

Email Address: _____

Previous Address in the last 10 years: _____

City: _____ State: _____ ZIP: _____ County: _____

By signing this form, I acknowledge that all information is true and correct to the best of my knowledge. I agree to receive all carrier required emails, and HealthPro Consultants Compliance updates.

☐ ***Additionally, by checking here, I agree to let HealthPro Consultants send me carriers, products, and lead opportunities.***

Preferred Method of Contact (can select multiple methods): ☐ Email ☐ Phone ☐ Text

_____ _____

INITIALS **DATE**

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BACKGROUND INFORMATION

All "Yes" Answers Must Have an Explanation to be Processed

Is there any indebtedness to any insurance company? If yes, provide the name of the company, amount, and the repayment agreement: ☐ Yes ☐ No

Have you ever been convicted of a felony or misdemeanor other than a traffic offense? If yes, explain and provide the date(s) of each: ☐ Yes ☐ No

Have you had your driver's license revoked? If yes, explain and provide date(s): ☐ Yes ☐ No

Are you in the process of, or have you ever, filed for bankruptcy? If yes, explain and answer the following questions: ☐ Yes ☐ No

Have you ever filed bankruptcy, have been declared bankrupt or insolvent, or have had your salary garnished? ☐ Yes ☐ No

Have you, or any business of which you were presently are a principal, been involved in a bankruptcy action, or compromised liabilities with creditors? ☐ Yes ☐ No

Have you ever filed a petition for bankruptcy or for protection from creditors? ☐ Yes ☐ No

Has any insurance or securities brokerage firm, with whom you have been associated, ever filed a bankruptcy petition or been declared bankrupt (either during your association or within 5 years after termination of such association)? ☐ Yes ☐ No

When was bankruptcy filed (MM/DD/YYYY)? ____ / ____ / _____

What was the amount of your bankruptcy? _____

Please select which you filed: ☐ Chapter 7 ☐ Chapter 11 ☐ Chapter 13

Please provide the date you filed for bankruptcy (MM/DD/YYYY): ____ / ____ / _____

Please provide the date your bankruptcy was paid off, (if applicable) (MM/DD/YYYY): ____ / ____ / _____

Are you now, or have you ever been, employed by, or associated with to any degree, directly or indirectly, a bank, savings and loan, or other financial institution? ☐ Yes ☐ No

Are you now subject of any complaint, investigation, or proceeding which could result in a yes answer to any of the preceding questions? ☐ Yes ☐ No

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Have you ever been refused a bond or Errors and Omissions Insurance? If yes, please explain: ☐ Yes ☐ No

Have you ever had your insurance license suspended or revoked? If yes, please explain: ☐ Yes ☐ No

Have you ever had disciplinary action taken against you with any Department of Insurance? If yes, please explain: ☐ Yes ☐ No

Are you, or at this present time, or have you been within the past five years, involved in any civil litigation, judgments, liens, or foreclosures? If yes, please explain: ☐ Yes ☐ No

Have you ever been denied an appointment with any insurance company? If yes, please explain: ☐ Yes ☐ No

Have you ever been terminated for cause by any insurance carrier? If yes, please explain: ☐ Yes ☐ No

BANKING INFORMATION

Bank Routing Number (9 digits): _____ Account Number: _____

Branch Name or Location: _____

*BE SURE TO ATTACH A **VOIDED CHECK**

OTHER INFORMATION

Requesting Commission Advancing? ☐ Yes ☐ No

List a Beneficiary: _____ Relationship: _____

Resident Driver's License State: _____ Driver's License Number: _____

Have you taken out an AML (Anti-Money Laundering) course within the past two years? ☐ Yes ☐ No

If yes, provide the date of the AML (Anti-Money Laundering):

Date (MM/YYYY): ____ / ____ Course Name: _____

Where were you born? (City,State) _____

LONG-TERM CARE PARTNERSHIP CERTIFICATION: Please Attach Certificate or CE Update

I confirm that all information is true and correct, and I have given HealthPro Consultants my permission to enter the information on my behalf.

_____ _____

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ADDITIONAL INFORMATION (SELECTHEALTH)

IF NOT SELECTING SELECTHEALTH AS A CARRIER, PLEASE DISREGARD THIS PAGE

PROFESSIONAL INFORMATION

Nevada Accident and Health Insurance License Number: _____

Issue Date (MM/DD/YYYY): ____ / ____ / ____ Expiration Date (MM/DD/YYYY): ____ / ____ / ____

Please list the names of the carriers with which you are currently appointed, or applying for appointment:

Have you ever been cited, fined, suspended, revoked, or refused a license by any state? ☐ Yes ☐ No

If yes, provide the state, month, and year: State: _____ Date (MM/YYYY): ____ / _____

Have you previously been appointed with SelectHealth? ☐ Yes ☐ No

Please list any languages, other than English, that you speak fluently: _____

PROFESSIONAL REFERENCES

List any professional associations to which you belong:

Name of Organization: _____ Member Since (MM/DD/YYYY): ____ / ____ / _____

Name of Organization: _____ Member Since (MM/DD/YYYY): ____ / ____ / _____

List two professional references that can attest to your honesty, professionalism, and ethical standards of practice:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

DISCIPLINARY ACTIONS

Have you ever been excluded from participating in a government healthcare program such as Medicaid or Medicare? ☐ Yes ☐ No

If yes, please provide complete background and detail of circumstances, paying particular attention to activities affecting interstate commerce, (if needed, you may attach another page):

By signing this form, I acknowledge that all information is true and correct to the best of my knowledge.

_____ _____

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LETTER OF EXPLANATION

Date of Action (MM/DD/YYYY): ____ / ____ / _____

Action: _____

Reason: _____

Explanation:

Date of Action (MM/DD/YYYY): ____ / ____ / _____

Action: _____

Reason: _____

Explanation:

Date of Action (MM/DD/YYYY): ____ / ____ / _____

Action: _____

Reason: _____

Explanation:

USE ADDITIONAL PAPER IF NECESSARY

LICENSES

AML Provider: ☐ Limra ☐ None ☐ Other Date Completed (MM/DD/YYYY): ____ / ____ / _____

If other, please provide certificate of completion.

Are you a Registered Rep with FINRA? ☐ Yes ☐ No

If yes, Broker/Dealer Name: _____ CRD#: _____

_____ _____

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AGENT REFERRAL INFORMATION

Agent Name: _____ Phone: _____ Relationship: _____

Agent Name: _____ Phone: _____ Relationship: _____

Agent Name: _____ Phone: _____ Relationship: _____

Agent Name: _____ Phone: _____ Relationship: _____

Agent Name: _____ Phone: _____ Relationship: _____

Agent Name: _____ Phone: _____ Relationship: _____

Agent Name: _____ Phone: _____ Relationship: _____

Agent Name: _____ Phone: _____ Relationship: _____

Agent Name: _____ Phone: _____ Relationship: _____

Agent Name: _____ Phone: _____ Relationship: _____

Agent Name: _____ Phone: _____ Relationship: _____

Agent Name: _____ Phone: _____ Relationship: _____

YOU CAN EARN EXTRA MONEY

CALL YOUR SALES DIRECTOR FOR MORE DETAILS ON OUR REFERRAL PROGRAM!

5005 ROCKSIDE RD, SUITE 600-209 | INDEPENDENCE, OH 44131 | 1 (216) 236-1466 | INFO@HEALTHPROCONSULTANTS.COM

_____ _____

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REPLACE THIS PAGE WITH A COPY OF YOUR E&O INSURANCE CERTIFICATE OF COVERAGE

IMPORTANT: E&O Certificate must list your full name as the insured.

Please use the following examples as reference:

CORRECT:

Name of Insurance Agency
Full Agent Name
Address Line 1
Address Line 2
City, State, ZIP

INCORRECT:

Name of Insurance Agency
Address Line 1
Address Line 2
City, State, ZIP

If an individual's name is not listed correctly, please provide a letter from the E&O Carrier listing agents covered under agency policy.

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SIGNATURE

GENERAL AGENT: HealthPro Consultants

I, _____, hereby authorize HealthPro Consultants to affix or append a facsimile of my signature, as set forth below, to all required signature fields on all Insurance Carrier documents through the software or through any other means, including without limitation, by e-mail or orally. For which I have authorized HealthPro Consultants to submit all such forms and agreements on my behalf, for the purposes of being Contracted to sell products of Carriers through HealthPro Consultants. I hereby release, indemnify and hold harmless HealthPro Consultants against any and all claims, demands, losses, damages, and causes of action, including: expenses, costs and reasonable attorneys' fees, which they may sustain or incur as a result of carrying out the authority granted hereunder.

I affirm that the information I have submitted through the interview process to HealthPro Consultants is correct to the best of my knowledge and acknowledge that I have read and reviewed the documents for which I am authorizing my signature to be affixed to. I acknowledge and agree to indemnify and hold harmless any third party from and against any and all claims, demands, losses, damages, and causes of action, including: expenses, costs and reasonable attorneys' fees, which such third party may incur as a result of its reliance and acceptance on any form or agreement of a facsimile of my signature.

By signing this form, I acknowledge that all information is true and correct to the best of my knowledge.

Please read, sign, and send back to info@healthproconsultants.com.
Additionally, please sign in the center of the box below:

EXAMPLE:

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Check the box next to the Carrier names that you would like to select. For non-resident state requests, please write in state next to the carrier. Please be advised that some carriers charge resident and-or non-resident appointment fees. If you are requesting non-resident appointment, please indicate what states in the block provided.

CARRIERS	✓	NON-RES STATES
Accendo		
Aetna Medicare Advantage/Coventry		
Aetna Medicare Supplement (ACI/ CLI)		
AGLA - Life with Living Benefits		
Alignment Health		
American Equity		
American General - Life Brokerage Annuity		
Americo		
Americo - Legacy		
Anthem BCBS/ Empire/ Amerigroup/ Caremore		
Assurity Legacy		
Athene Annuity & Life Assurance Company		
Athene, IA - Annuity		
Baltimore Life		
Banker's Fidelity Life/ Assurance Company		
BayCare		
BayCare		
BCBS MI		
Brighthouse Financial		
Capitol Life - Med Supp		
Centene		
Centene/ Allwell		
Cigna - Final Expense/ Med Sup (Arlic/ Loyal American/ CHLIC)		
Cigna - HealthSpring (Bravo Health)		
Clover Health		
Columbian Mutual Life Insurance Company		
Combined Insurance Company of America		
Devoted		
Equitable Annuity		
Equitrust		
F&G		
F&G (Legacy)		
Foresters Financial		
Foresters Life		
Freedom/ Optimum		
Fresenius		
Gerber Life - Medicare Supplement		
Gerber Life Insurance Company		
Global Atlantic		
Great American		

CARRIERS	✓	NON-RES STATES
Great Western - GI Life		
Guarantee Trust Life		
HealthFirst		
Humana		
John Hancock		
Lincoln Financial		
LUMICO MS		
Medico Group		
MOO MA		
Mutual of Omaha Insurance Company (Omaha Insurance, United of Omaha Life Ins., United World Life Ins.)		
National Care Dental		
National Guardian Life		
National Guardian Life - Med Supp		
National Life Group		
National Western		
Nationwide		
North American Company (NACOLAH) - Life & Annuity		
Oceanview		
Oscar Health		
Protective Life		
Prudential		
Regence		
Royal Neighbors of America		
SCAN		
SelectHealth		
Sentinel Security Life Insurance Company		
Simply		
Sons of Norway		
The Standard		
Thrivent- Med Supp		
Transamerica New York		
Transamerica Premier		
United Home Life		
United Security Assurance		
UnitedHealthcare		
USIC MS		
Washington National		
WellCare		
William Penn		
Other:		

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