



321 Middle Country Road
PO Box 863
Smithtown, NY 11787
Phone: 631-265-7456 Fax: 631-265-7054
www.victorson.com

Dear Producer,

Welcome to Victorson Associates, Inc.! Attached you will find the **Atlantis Health** contracting paperwork you requested. Please forward completed paperwork back to me at above address, e-mail or fax for processing.

Please be thorough in completing the forms. Once you have them completed, please take a moment and make sure you have attached the following:

1. Completed and signed contracting paperwork
2. Make sure the direct deposit form is completed w copy of voided check, suggested.
3. Include copy of your state life and health license and proof of E & O coverage.

.At Victorson Associates, Inc. we appreciate your business. Once we receive notice that your appointment with the carrier is complete we will e-mail you confirmation.

If you have any questions at all, please feel free to contact me.

Sincerely,

Linda DePinto

Linda DePinto
Licensing Coordinator
lindad@victorson.com

BROKER APPOINTMENT POLICY & PROCEDURES

Please follow these steps in order to become an Atlantis Health Plan Selling Agent.

1. Complete and sign the Broker Contract.
2. Complete and sign the Selling Agent Application form.
3. Include a copy of your current State of New York Insurance Department Life, Accident, and Health Agent License or Broker License. If applying as a corporation; include both parts of the corporate license. You must be licensed to sell insurance in New York State.
4. Include a copy of errors and omissions; minimum of \$1,000,000 policy coverage.
5. To receive commissions through Direct Deposit, please complete and sign the Direct Deposit Authorization form and attach a voided check.

Atlantis Health Plan will begin paying commission upon completion of the above procedures.

Please send the completed booklet with signed documents to your General Agent :




Victorson Associates, Inc.
www.victorson.com

321 Middle Country Rd., PO Box 863
Smithtown, NY 11787
(631) 265-7456 Fax: (631) 265-7054



SELLING AGENT APPLICATION FORM

Agent Information			
Applicant		Date of Birth	
Business Address			
City	State	Zip Code	
Business Phone Number	Business Fax Number	Agent E-Mail Address	
Agency Taxpayer I.D. or Social Security Number		Agent License Number	
General Agency Information			
General Agency Name			
General Agency Address			
City	State	Zip Code	
Agency Code		Agency E-Mail Address	
Other Appointment			
List other companies to which the applicant has been appointed in the last five years.			
Errors and Omissions Coverage			
Does the applicant carry Errors and Omissions Coverage?			
<input type="checkbox"/> No		<input type="checkbox"/> Yes	
Officers and Directors			
List all officers and directors and give information requested below. If sub-licenses, check box(es) and list before other officers and directors.			
Last Name	First	Middle	Date of Birth
Title of Officer	Social Security Number	Check here if Sub-license <input type="checkbox"/>	
<p>Note: The Selling Agent Appointment Application Form must be completed and returned, along with a copy of your current State of New York Insurance Department Life, Accident, & Health Agent License to:</p>			
 <div style="display: inline-block; vertical-align: middle; margin-left: 10px;"> <p>Victorson Associates, Inc. www.victorson.com 321 Middle Country Rd., PO Box 663 Smithtown, NY 11787 (631) 265-7456 Fax: (631) 265-7054</p> </div>			



Background Information (To be supplied by agent)

1. Has anyone named on this application ever been known by any name other than one listed on this application?

No

Yes (Give details below)

2. Has anyone named on this application ever been refused a license for insurance or had a license for insurance revoked or suspended?

No

Yes (Give details below)

3. Has anyone named on this application ever been fined or formally disciplined by any insurance department or any state or government agency or authority?

No

Yes (Give details below)

4. Has anyone named on this application ever been charged or investigated; in any capacity whatsoever, with financial irregularities, misconduct or authority?

No

Yes (Give details below)

5. Has the applicant ever had its agency appointment terminated for cause or for any of the above reasons?

No

Yes (Give details below)

6. Other than traffic infractions or "Youthful Offender" adjudications, has anyone ever been convicted of a crime?

No

Yes (Give details below)



Note: If you answered "Yes" to any of the above questions, please give all relevant dates, places, states and names where applicable. Attach additional information if necessary.

I hereby certify that the information provided on this application is true and complete to the best of my knowledge.

Signature of Applicant (Selling Agent)

Date

As part of the procedure for processing this application for appointment with Atlantis Health Plan, an investigative report may be made. Such report will be confidential and will be used for purposes of evaluating applicants qualification for appointment and you may have the right to request, in writing and within a reasonable period of time, a complete and accurate disclosure of additional information concerning the nature and scope of such investigation or report.

I hereby request the appointment of the above applicant:



Signature of Applicant (Selling Agent)

Date

FOR INTERNAL USE ONLY

General Agent _____ Date _____

Selling Agent _____ Date _____



Direct Deposit Agreement Form

Authorization Agreement

I hereby authorize **Atlantis Health Plan** to initiate automatic deposits of all of my commissions to my account at the financial institution named below. I authorize **Atlantis Health Plan** and **ADP** to withdraw any funds deposited in error into my account.

Further, I agree not to hold **Atlantis Health Plan** responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until **Atlantis Health Plan** receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to **Atlantis Health Plan**.

Broker Name: _____ Broker/GA Number: _____

Tax ID Number: _____ Telephone Number: _____

Account Information

Checking Savings

Name of Financial Institution: _____

Routing Number: _____

Account Number: _____

Effective Date: _____

Cancellation of Authorization

Signature

Authorized Signature (Primary):  _____ Date: _____

Authorized Signature (Joint): _____ Date: _____

Please attach a voided check or deposit slip and return this form to:
Atlantis Health Plan
Attention: Sales Support & Installation
45 Broadway, Suite 300
New York, NY 10006

AHP-00113
Revised 04/08



Victorson Associates, Inc.
www.victorson.com

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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"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ <input type="checkbox"/> Exempt payee <input type="checkbox"/> Other (see instructions) ▶	
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 ▶
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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,

BROKER CONTRACT

This agreement is made by and between Atlantis Health Plan, Inc. (AHP) having our principal place of business at 45 Broadway, Suite 300, New York, N.Y., 10006 and

Full Name: _____

Number and Street: _____

City: _____ State: _____ Zip: _____

Herein referred to as the "Broker", effective _____.

The parties, intending to be legally bound, hereby agree as follows:

1. AUTHORITY

You may solicit employers and other groups not then currently offering AHP healthcare benefits to their employees or members.

2. LIMITATIONS OF AUTHORITY

This agreement does not give you any power or authority other than that which is expressly granted herein and no other or greater power shall be implied from the granting or denial of powers specifically mentioned herein. You are not authorized to make, alter or discharge any contract in our name; to bind us by any statement or promise; to reject or accept any employer or group which you solicit; to incur any liability on our behalf; to waive, alter or amend the performance, provisions, terms or conditions of premiums or other money due, or to collect, handle or receive any premiums on our behalf. You are not authorized to make any payment to any party in connection with this agreement unless such payment is first authorized by us in writing. You shall only use advertising material, proposals and other marketing literature or material furnished by us unless otherwise previously approved in writing by us. You shall not issue or circulate any illustration, circular, statement or other information of any sort misrepresenting the terms, benefits or advantages of any coverage issued by us or information pertaining to the financial position of AHP.

3. RELATIONSHIP OF THE PARTIES

The Broker is an independent contractor of AHP and no employer/employee relationship exists between Broker or its agents and AHP. As an independent contractor, the broker reserves the right to exercise independent judgment as to the time, place and manner of soliciting applications for insurance.

4. COMPENSATION

AHP will pay you, in a timely manner, a commission in accordance with the Broker Compensation Plan set forth in Exhibit A to this agreement as amended or modified by us from time to time. This Compensation Plan will be adjusted to conform to New York State law at all times. You will be paid

the applicable commission on first year and renewal premiums procured by you and actually received in cash by AHP. Commissions will be paid within 30 days of receipt of premium.

The Compensation Plan may be changed from time to time by AHP. You will receive written notification of such change; however, no change will affect fees earned by you on premiums paid prior to the date of a change.

Commissions paid by AHP to you shall constitute full compensation for your services performed in accordance with this agreement. You are responsible for all expenses incurred by you in performance of this agreement. If, for any reason, we refund part/all of the premium to an employer or group, or the contract between AHP and the employer or group is terminated for any reason, the commission payable to you will be adjusted to reflect the same. You shall be entitled to a commission for as long as you remain designated broker of record. If an employer or group provides us with notification of a change of broker of record, your entitlement to commissions with respect to such employer or group shall terminate at the close of business on the effective date of designated broker of record change.

5. ASSIGNMENT

Broker's commission may not be assigned without Atlantis' prior written approval. In no event, shall AHP be responsible for the validity or consequence of any such assignment or for any consequence of any mailing, forward or payment instruction given to us by you.

6. TERMINATION

At any time, agreements may be terminated by either AHP or the broker by written notice mailed to the other at the last known address of the other party. Termination shall not impair your rights to receive commission payable hereunder in respect to premiums paid prior to termination. If, for whatever reason, we do not insist upon your performance of any condition of this agreement, it in no way shall constitute a waiver of our rights and privileges hereunder.

This agreement automatically terminates upon the Broker's death.

7. INDEMNIFICATION

The Broker agrees to indemnify, defend and hold harmless AHP and its directors, officers, employees, successors and assignees from and against any and all claims, penalties, liabilities, losses, damages, suits, settlements, judgments, or costs, including reasonable attorney's fees, which may arise from the acts or omissions of the Agents/Brokers, officers or employees in performing under this Agreement.

The Broker shall maintain, during the term hereof all insurance required by law, including Professional Liability or Errors and Omissions insurance. Broker shall maintain Errors and Omissions insurance during the term of this agreement in an amount reasonably required by Atlantis Health Plan, but in no event less than one million (\$1,000,000) dollars. Broker shall provide evidence to AHP that such coverage is in force prior to the execution hereof, and from time to time upon Atlantis' request. Broker shall notify AHP immediately upon notice that such insurance is or will be reduced, modified, cancelled or terminated.

8. BROKER'S LICENSE AND TERRITORY

You will comply with the Insurance Laws and Regulations of New York State in which you are properly licensed to solicit business on behalf of a health maintenance organization. A copy of your current Broker's license is attached as Exhibit B to this agreement. If your license is suspended, revoked or not renewed by New York State, your right to solicit business on our behalf in New York State will be suspended until such time as your license is reinstated or renewed. You have the obligation to inform us immediately in the event that you receive notification that any state regulatory or licensing body intends to suspend, revoke or not renew your license. You are also obligated to notify us immediately in the event that your license is suspended, revoked or not renewed.

The territory in which you are licensed to represent Atlantis Health Plan is not exclusively assigned to you and we have the right to enter into similar arrangements with others and you have the same right.

IN WITNESS WHEREOF, the parties hereby cause this Agreement to be executed by their duly authorized representatives.

INDIVIDUAL

X

Broker Signature

Broker Print Name

Date

Social Security Number

OR

CORPORATE BROKER

X

President Signature

President Print Name

Date

Federal Tax # or Social Security #

ATLANTIS HEALTH PLAN, INC.

Signature

Print Name

Title

Date



Exhibit A

**BROKER COMMISSION SCHEDULE
2010**

<u>Product</u>	<u>Commission</u>	<u>Renewal</u>
HMO	4%	4%
POS	4%	4%
Healthy New York	4%	4%

This schedule is for Community rated groups of 1-50.

Exhibit A
AHP-00125
S&M Revised 04/08

