SENIOR MARKETING SPECIALISTS

Omaha Health PDP

Contracting Checklist

Please submit the following information to **SMS** when licensing with MOO PDP:

- **Completed and Signed Contract Information and Signature Forms**
- **Voided Check**
- **Copy of Agent/Agency license (s)**
- **E&O Certificate** *(required)*

Please return all contracting to Senior Marketing Specialist via:

Mail:
801 Gray Oak Dr
Columbia, MO 65201

Email: contracting@smsteam.net
Fax: 800-878-2025

The licensing process cannot begin until all of the above items have been received! If you have any questions, please call us at: 1- 800-689-2800.

SENIOR MARKETING SPECIALISTS

Contracting Information Form

Please complete the below and return it with your contracting paperwork:

Agent Name: _____

Carrier Name: _____

1. **Have you or your agency (if applicable) ever been contracted previously? (Y/N)**

   _____

If you answered 'yes' to the question above, please complete the below:

2. What date did you contract?

_____

3. How were you contracted (indv. or corp.)?

_____

4. Do you have any downline agents?

_____

5. When was the last time you or your downline (if applicable) wrote a piece of business?

_____

OMAHA HEALTH INSURANCE COMPANY

Contract Information and Signature Form

If contracting as a:

Producer only - complete sections 1, 3 & Individual FCRA Authorization Form
Business Entity only - complete sections 2 & 3
Business Entity & Principal- complete sections 1, 2, 3 (both signature blocks) & Individual FCRA Authorization Form

Section 1

Producer Information *(Required)*

Name: _____ SSN: ___-___-____ DOB: ___-___-____

Home Address: _____ (Not a P.O. Box) _____ (City) ____ (State) _____ (Zip Code)

Business Address: _____ (P.O. Box Accepted) _____ (City) ____ (State) _____ (Zip Code)

Primary Phone Number: ___-___-_____ Business Phone: ___-___-_____ Email Address: _____

Managing General Agent (if applicable)_____

Compliance Contact: _____ Phone:___-___-_____ Email Address:_____

Errors & Omission Insurance *(As Required)*: _____ (Carrier Name) $_____ (Minimum $1M Per Claim)

Background Information *(Required - Must be answered)*

☐ Yes ☐ No	Has any regulatory authority, such as an insurance department, FINRA, CMS, OIG or the SEC **ever** fined or suspended you, placed you on probation, assessed you any administrative costs, entered into a consent order with you, issued you a restricted license, or otherwise disciplined you? Are you currently under investigation by any regulatory authority, such as an insurance department, FINRA, CMS, OIG or the SEC? Are you or have you ever been excluded from participation in Medicare or any other federal program or ever appeared on the OIG or SAM exclusion list?
☐ Yes ☐ No	Other than minor traffic offenses that did not result in harm to a person or property, have you **ever** been (1) convicted of any offense, (2) pled guilty or nolo contendre (no contest) to any offense?

NOTE: Answering "YES" to the above questions does not automatically preclude you from being contracted.

If Yes, please include county _____

Directions: PLEASE PROVIDE A WRITTEN EXPLANATION for any "YES" answer including the disposition and applicable supporting documentation (court documents, insurance department documents etc.). Failure to answer "YES", when appropriate, may result in denial of your request to be contracted.

Contracting Selection *(Required)* **Please review our Online Privacy Policy at www.mutualofomaha.com/privacy**

☐	I have received, reviewed and agree to be bound by the Terms & Conditions of the ***General Agent Agreement*** with Omaha Health Insurance Company ***(BMO171.004)*** Please retain a copy of the agreement for your files. A copy will not be returned to you.
☐	I have received, reviewed and agree to be bound by the Terms & Conditions of the ***Special Agent Agreement*** with Omaha Health Insurance Company***(BMO172.004)*** Please retain a copy of the agreement for your files. A copy will not be returned to you.

Direct Deposit Information *(Required for General Agents)*

Financial Institution: _____

Routing Number: _____ Account Number:_____ Account Type ☐ Checking ☐ Savings

This is not an assignment of commissions. Form 1099 will be issued to the commission owner.

Designation of Beneficiary *(if applicable)*

Name: _____ (First Name, Middle Initial, Last Name or Business Name)

Home Address: _____ (Not a P.O. Box) _____ (City) ____ (State) _____ (Zip Code)

SSN: ___-___-___ or TIN: ___-_____ DOB: ___-___-_____ Phone Number: ___-___-_____

W-9 Information

Taxpayer Identification Number (SSN)

Enter your TIN in the appropriate box. For individuals, this is your social security number. For other entities, it is your employer identification number.

Social Security Number _____--- _____--- _____

Certification

Under penalties of perjury, I certify that:

1. The number provided is my correct taxpayer identification number, 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 (a U.S. citizen or U.S. resident alien or a partnership, corporation, company or association created or organized in the U.S. or under the laws of the U.S. or an estate (other than a foreign estate) or a domestic trust (as defined in Regulations section 301.7701-7).

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.

The Internal Revenue Service does not require your consent to any provision of this document other than the above-referenced certifications required to avoid backup withholding.

Sign Here	Signature of U.S. Person ➔	SIGN HERE	Date➔

Contract Information and Signature Form

Section 2

Business Information *(Only complete this section if contracting as an Incorporated Entity, Partnership or LLC)*

Name: _____ TIN: ____-_____

Doing Business As: _____

Address: _____ _____ _____ _____
P.O. Box Accepted City State Zip Code

Phone: _____- _____- _____ Email Address: _____

Principal Officer: _____

Contracting Selection *(Required for Corporation)*

☐ I have received, reviewed and agree to be bound by the Terms & Conditions of the ***General Agent Agreement*** with Omaha Health Insurance Company ***(BMO171.004)***
Please retain a copy of the agreement for your files. A copy will not be returned to you.

Direct Deposit Information (*Required for Corporation)*

Financial Institution: _____

Routing Number: _____ Account Number: _____ Account Type ☐ Checking ☐ Savings

This is not an assignment of commissions. Form 1099 will be issued to the commission owner.

W-9 Information

Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number. For other entities, it is your employer identification number.

Employer Identification Number _____--- _____

Certification

Under penalties of perjury, I certify that:

1. The number provided is my correct taxpayer identification number, 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 (a U.S. citizen or U.S. resident alien or a partnership, corporation, company or association created or organized in the U.S. or under the laws of the U.S. or an estate (other than a foreign estate) or a domestic trust (as defined in Regulations section 301.7701-7).

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.

The Internal Revenue Service does not require your consent to any provision of this document other than the above-referenced certifications required to avoid backup withholding.

Sign Here	Signature of U.S. Person ➔ SIGN HERE	Date➔

*******Please proceed to Section 3********

Section 3 - Contract Signature, Certification and Direct Deposit Authorization

By signing below:
(a) you agree to be bound by the terms and conditions of the Agreement(s) selected,
(b) you certify that the information that you have provided is true and correct and you agree that you will report immediately any event that would change any of the information, in any manner, which you have provided,
(c) you agree to maintain your state insurance license in good standing, stay current with required continuing education, and obtain and maintain E&O coverage as required, and
(d) **if you have completed the Direct Deposit section(s)** you authorize Omaha Health Insurance Company ("OHIC") to electronically credit the bank account and, if necessary, to electronically debit the account to correct erroneous credits. You understand that this authorization will remain in full force and effect until you notify Company that you wish to revoke this authorization.

Producer Signature

Name: _____ SIGN HERE
(Signature Required)

Date: _____

********Please proceed to the FCRA Authorization Form********

Business Signature (If Signing on the behalf of the Business)

Name: _____ SIGN HERE

Title: _____
(Required)

Date: _____

State Appointment Requests- To add the appointment the producer must have an active state license

Please mark the state appointments to be added for this producer: Please include license copies, grid or NIPR report.

If no copies, grid or NIPR report are received only the resident state will be added

Producer Name _____ SSN/Producer Number _____

- ☐ All States Licensed
- ☐ Alabama
- ☐ Alaska
- ☐ Arizona
- ☐ Arkansas
- ☐ California
- ☐ Colorado
- ☐ Connecticut
- ☐ Delaware
- ☐ Florida
- ☐ ***Georgia**
- ☐ Hawaii
- ☐ Idaho
- ☐ Illinois
- ☐ Indiana
- ☐ Iowa
- ☐ Kansas
- ☐ Kentucky
- ☐ Louisiana
- ☐ Maine
- ☐ Maryland
- ☐ ***Massachusetts**
- ☐ Michigan
- ☐ Minnesota
- ☐ Mississippi
- ☐ Missouri
- ☐ ***Montana**
- ☐ Nebraska
- ☐ Nevada
- ☐ New Hampshire
- ☐ New Jersey
- ☐ ***New Mexico**
- ☐ New York
- ☐ North Carolina
- ☐ North Dakota
- ☐ Ohio
- ☐ ***Oklahoma**
- ☐ Oregon
- ☐ ***Pennsylvania**
- ☐ Rhode Island
- ☐ South Carolina
- ☐ South Dakota
- ☐ Tennessee
- ☐ Texas
- ☐ Utah
- ☐ Vermont
- ☐ ***Virginia**
- ☐ Washington
- ☐ West Virginia
- ☐ Wisconsin
- ☐ Wyoming

***IMPORTANT NOTICE REGARDING COMPENSATION:**

Entity Type	State
• Licenses and Appointment required for both Individuals and Corporations. • **License must be effective prior to the policy application sign date**	Montana Virginia
• Licenses and Appointment required for both Individuals and Corporations	Georgia Massachusetts New Mexico Pennsylvania

***If individuals and corporations do not follow the above guidelines for the states referenced, compensation will be held on anyone in the hierarchy who does not hold the license and appointment.**

***States listed in either red or half red & blue are pre-appointment states and require the producer to be appointed prior to soliciting business**

FAIR CREDIT REPORTING ACT DISCLOSURE

Disclosure Regarding Consumer Reports

Omaha Health Insurance Company ("OHIC") may obtain and use consumer reports about you in order to evaluate your eligibility to contract with OHIC as an insurance producer or to remain contracted as an insurance producer for OHIC.

Your Authorization

By signing below, I authorize OHIC to obtain and use consumer reports about me in order to evaluate my eligibility to contract with OHIC as an insurance producer. If I do contract with OHIC as an insurance producer, by signing below, I also authorize OHIC to obtain and use consumer reports about me while my contract is in effect in order to evaluate my continued eligibility to remain an insurance producer for OHIC.

Candidate Signature

Date

Print Name

Additional Information About Consumer Reports

Consumer reports may include, among other things, information about your credit history, criminal record and history, and insurance department regulatory actions.

We will obtain a copy of your consumer report from:

Name/Address/Phone

For California, Minnesota and Oklahoma: You have a right to request a copy of the consumer report which will disclose the nature and scope of the report.

☐ Yes, please provide me a copy of the consumer report

For New York: You have a right, upon written request, to be informed of whether or not a consumer report was requested. If a consumer report is requested, you will be provided with the name and address of the consumer reporting agency furnishing the report.