

Revised 2.1.09

This packet only applies to agents who have an existing appointment with Golden Rule and wish to transfer to AHCP – if you are a new Golden Rule Agent go to <https://secure.ameri-choice.com/enroll/pdf/GoldenRuleAppointmentPacket.pdf> to retrieve your contracting package.



FAX to 972.915.3288

Or

E-mail contracting@AHCPsales.com

GOLDEN RULE

UnitedHealthcare[®]

Underwritten By Golden Rule

CONTRACTING AND APPOINTMENT PAPERWORK

Print Agents Name

Agents Contract Level

E-mail address

Phone number

Print Direct Uplines Manager/Agent name

FAX TO 972.915.3288 or E-mail a scanned copy to contracting@AHCPsales.com

SUB-BROKER CONTRACT CHANGE REQUEST/ASSIGNMENT FORM

Subject to acceptance by UnitedHealthcare, or any of its affiliates, please change my existing contract with UnitedHealthcare to show I am a sub-broker under the Key Broker contract between **020690863B - America's Health Care Plan AHCP** and UnitedHealthcare.

Key Broker

- Pay Commissions directly to me, and the override to the Key Broker.
- Pay Commissions to agency tax id # _____ and the override to the Key Broker.
- Pay Commissions directly to the Key Broker.

Agreed and accepted:

Must be completed by the Sub-Broker

Sub-Broker: _____		
X		
Sub-Broker Signature		
Printed Name		
Producer Number		
Date		
Address		
City	St	Zip

Must be completed by the Key Broker/Principal

Key Broker: America's Health Care Plan- AHCP		
By: _____		
X		
Authorized Signatory of Agency		
Printed Name		
0000052896 F3A02		
Tax ID Number	Agency Code	
Date		
4929 W. Royal Lane, Suite 200		
Address		
Irving	TX	75063
City	St	Zip
Do you authorize this Sub-Broker to be advanced?		
<input type="checkbox"/> Yes <input type="checkbox"/> No		

Accepted by UnitedHealthcare:

Golden Rule National Key Broker Sales Manager

Date

Effective Date: _____

Brokers that have written more than 2 individual health applications with UnitedHealthcare in the last 6 months are not eligible to transfer.

KB Status	KB # of Subs	KB # of Subs Allowed	KB Past 12mth Prod
Broker past 6mth Prod	Current Agency Code	Appointment Date	

ASSIGNMENT OF COMMISSIONS AND OTHER COMPENSATION

To: Golden Rule Insurance Company and/or American Medical Security Life Insurance Company and/or PacificCare Health Plan Administrators, Inc., and/or United Healthcare Insurance Company, and/or any affiliated company (collectively, "the Company").

If and when the Company owes me compensation because I have sold or secured the sale of insurance products of the Company or for any other reason, I (the undersigned "Assignor") do not wish to receive that compensation, but instead assign all of the compensation to, and direct the Company to pay all of it to, the person or entity I have written below as Assignee:

<u>AHCP</u>		<u>000005289B</u>		
Assignee Name (person/entity to be paid)		Social Security/tax ID Number		
<hr/>				
Street	City	State	ZIP	Phone

This Assignment applies to (select ONE):

- all first year and renewal compensation; or
- all compensation attributable to my business written *after* the date this form is processed by the Company (unless for compensation attributable to my business written prior to the date this form is processed by the Company for which my Assignee has received advances on the compensation related to such business, in which case the assignment applies to all business written after the effective date of the Commission Advance Agreement (the "Advance Agreement") between the Company and my Assignee).

I understand and agree that:

1. Payments made by the Company pursuant to this Assignment fully discharge all of the Company's financial obligations to me under any compensation arrangement between us (individually or collectively the "Contract").
2. This Assignment is subject to, and does not affect, any terms or conditions of the Contract except as specifically provided herein.
3. This Assignment is subject to applicable state and federal laws regarding assignment of commissions by insurance producers (by whatever name called). The Company will not be bound by this Assignment in any instance in which it believes applicable law prevents it from paying the Assignee, and it then may pay the person or entity that it, in its sole discretion, determines to be appropriate under the circumstances.
4. This Assignment shall remain in effect, and is binding on both myself and the Company, until revoked. I may revoke this Assignment by sending written notice to the Company. Such revocation will only apply to business written after the effective date of the revocation, and this Assignment will remain in effect for business written for the Company prior to that date. Revocation will be effective on the latter of the date I request, or thirty (30) days after the Company's receipt of the notice.
5. This Assignment does not apply to merchandise, trips or other non-cash incentives, awards, contests or other remuneration (collectively "prizes") that the Company may offer from time to time. It also does not apply to a cash equivalent in the event either I or the Company choose to remit or accept such cash equivalent in lieu any particular prize.
6. Assignor understands the Assignee may enter into an Advance Agreement with the Company. The Advance Agreement entitles the Assignee to receive an advance on the payment of compensation for business issued by Company after the effective date of the Advance Agreement. Assignor understands and acknowledges that the Company, as a condition to agreeing to the Advance Agreement, requires the Assignee obtain an assignment of commissions from all sub-brokers, including Assignor.

Assignor Signature

Assignor Printed Name

Date Signed

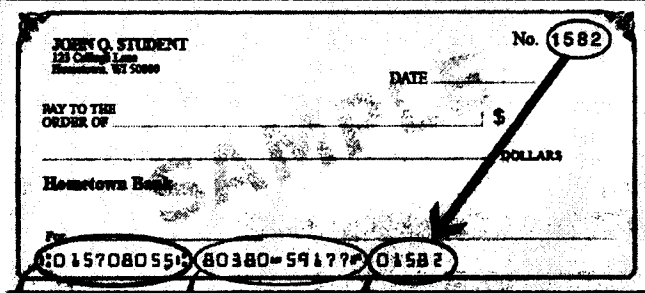
UnitedHealthcare

UnitedHealthcare of New York

Authorization for Automatic Deposit

I (We) Hereby authorize AHCP to initiate direct deposit of commissions and, if necessary, make corrections for any entries made to my account in error.

Agent or Agency Name	
Social Security Number or Tax ID Number	
Phone Number	Email Address
Please indicate transaction type: <input type="checkbox"/> Set-Up <input type="checkbox"/> Change <input type="checkbox"/> Cancel	
Please indicate type of account: <input type="checkbox"/> Checking <input type="checkbox"/> Savings	
Name of Financial Institution:	
Bank—City, State, Phone Number:	
Routing Number:	
Account Number:	



The routing/
transit number is
denoted by nine
digits surrounded
by ⑆

The checking
account number*

The check number*

*In some cases the order of the
checking account number and
the check number is reversed

If you don't have paper checks, contact your bank to obtain your bank routing number and account number information

Agent Signature _____ Date _____

PLEASE INCLUDE A COPY OF A VOIDED CHECK