Print Form

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 or:

Atlantis Health Plan
Attention: Sales Support & Installation
45 Broadway, Suite 300
New York, NY 10006

ATLANTIS HEALTH PLAN
By Doctors. For New Yorkers.

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

_____
Broker Signature

_____
Broker Print Name

_____
Date

_____
Social Security Number

OR

CORPORATE BROKER

_____
President Signature

_____
President Print Name

_____
Date

_____
Federal Tax # or Social Security #

ATLANTIS HEALTH PLAN, INC.

_____
Signature

_____
Print Name

_____
Title

_____
Date

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Exhibit A

BROKER COMMISSION SCHEDULE
2010

Product	Commission	Renewal
HMO	4%	4%
POS	4%	4%
Healthy New York	4%	4%

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

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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?

☐ No ☐ 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 ☐	

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:

Atlantis Health Plan
Attn: Sales Support & Installation
45 Broadway, Suite 300
New York, NY 10006

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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)

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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 _____

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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

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