



LONG TERM CARE INSURANCE
Contracting Kit

CARRIER: **PHYSICIANS MUTUAL**
CURRENT AS OF 5/10/06

IMPORTANT: CARRIER REQUIRES THAT **EVERY PAGE** IN THIS ENTIRE KIT BE REVIEWED, COMPLETED, OR SIGNED AND RETURNED TO CPS INSURANCE SERVICES. PLEASE CALL (949) 225-7113 WITH ANY QUESTIONS.

By Mail
CPS INSURANCE SERVICES
ATTN: Long Term Care
18551 VON KARMAN AVE, SUITE 150
IRVINE, CA 92612

- OR -

By Fax
CPS INSURANCE SERVICES
ATTN: Long Term Care
(949) 225-7113

**IF YOU ARE IN ONE OF THE FOLLOWING PRE-APPOINTMENT STATES,
YOU MUST BE APPOINTED BY PHYSICIANS MUTUAL PRIOR TO
SOLICITING LTC BUSINESS**

Georgia New Mexico Washington

<input checked="" type="checkbox"/>	INSTRUCTIONS
<input type="checkbox"/>	Be certain to review, complete, or sign every page of entire appointment packet. After you have done so, make copies for yourself. This is a contract between you and the Insurance Company.
<input type="checkbox"/>	Include a copy of your current resident insurance license
<input type="checkbox"/>	Include a copy of your E&O Insurance Certificate
<input type="checkbox"/>	<p>If you are in the following states, include a copy of your required Long Term Care Course Certification:</p> <ul style="list-style-type: none">• CALIFORNIA – <i>California Long Term Care</i> or CTQ 8-hr CE• COLORADO – <i>Colorado Long Term Care</i> 2-hr CE• DELAWARE – <i>Delaware Long Term Care</i> 3-hr CE• ILLINOIS – <i>Traditional Long Term Care Insurance Policy</i> 6-hr CE• INDIANA – <i>Indiana Long Term Care</i> 8-hr CE• MARYLAND – <i>Maryland Long Term Care</i> 2 hr CE• WASHINGTON – <i>Washington State Long Term Care</i> 6-hr CE

Physicians Mutual Insurance Company® Physicians Life Insurance Company®

Contracting Checklist

- ☐ Sales Agreement: CCxxx (be sure to sign the last page)
- ☐ Contracting Transmittal Form (ASF132)
- ☐ Compensation Schedule (be sure to sign the last page of each compensation schedule)
 - _____ Annuity: CCxxxCS-Ann
 - _____ LTC: CCxxxCS-LTC (be sure to sign the last page of compensation schedule even though page says WI)
 - _____ Life: CCxxxCS-Life
- ☐ Appointment Application: ASF107
- ☐ W9
- ☐ Direct Deposit Authorization Form: ASF131 (we will make deposits only, no authorization to withdraw)
- ☐ Voided Check for Direct Deposit
- ☐ Copy of licenses (for each state requesting appointment)
- ☐ LTC CE requirements*
- ☐ HIPPA Disclosure: AL107
- ☐ Kansas and Kentucky require E & O insurance (please send copy of insurance)

***For Long Term Care, credits are required in the states of CA*, IL, IN, MD and WA. Submit your certificate with your contracting.**

- California
 - Requires certificate every two years. Please submit a copy of the certificate.
- Florida (Non-resident)
 - For license, please specify county.
- Georgia (Resident and Non-resident)
 - To be appointed we will need your original signature on appointment form.
- Maryland
 - Send in copy of Education Credits for LTC with contracting
- West Virginia (Non-resident)
 - Licenses require your original signature on the appointment form.

**Physicians Mutual Insurance Company
Physicians Life Insurance Company
Contracting Transmittal Form**

Thank you for submitting contracting with Physicians Mutual Insurance Company/
Physicians Life Insurance Company. In order to avoid any delays in processing this
paperwork, please complete the attached chart. This information will allow the Home
Office to properly establish your hierarchy and pay your commissions correctly.

The attached agent's hierarchy should be as follows (only complete the levels that apply):

Name of Agent being submitted: _____

<u>Level</u>	<u>Agent Number</u>
BGA	<u>450000</u>
EGA	<u> </u>
GA	<u> </u>
AGA	<u> </u>
Agent	<u> </u>
Associate Agent/Solicitor	<u> </u>

Physicians Mutual Insurance Co.
Physicians Life Insurance Co.
Producer Sales Agreement

This Agreement made on _____ between Physicians Mutual Insurance Company and/or Physicians Life Insurance Company (collectively the "Company") and _____ (the Producer) shall be as follows:

APPOINTMENT

You are hereby appointed as a Producer of Physicians Mutual Insurance Company and/or Physicians Life Insurance Company, subject to the terms and conditions of this Agreement.

You understand and agree that your relationship with the Company is that of an independent contractor.

RESPONSIBILITIES

You agree to:

- (a) Treat all monies received or collected by you for the Company as property held in trust, remit such monies at once to the Company with a full and detailed statement, and not commingle or divert monies in any manner.
- (b) Procure applications for those policies listed in the attached compensation schedules (the "Policy" or collectively, the "Policies"), providing necessary service to Agents and Policyholders. It is understood that the Company has the right to reject, in its sole and absolute discretion, applications for Policies obtained by the PRODUCER.
- (c) Be governed strictly by all rules, regulations and instructions contained in the Company sales materials and manuals, together with all other regulations instituted from time to time, and observe and comply with the insurance laws and regulations of the state(s) in which you operate.
- (d) Hold all sales materials and supplies furnished you by the Company as property of the Company, and treat all books of account, card records, documents, vouchers, and papers connected with the business written in this Company as property of the Company and at any and all times subject to examination by the Company.
- (e) Hold information regarding the Company's Policyholders, including, but not limited to, names of Policyholders, other information concerning Policyholders or their policies, current status report forms, and lists showing Policyholders, whether such materials were in existence before your appointment, or are created during your term as PRODUCER, as confidential material and trade secrets of the Company, holding such information in trust for the Company. You further agree that when you are acting on behalf of the Company and you learn financial information about a person, you can disclose that information to the Company or Physicians Mutual Services Corporation (the "Affiliates"). You further agree you cannot disclose the financial information to a non-Affiliate unless you first comply with the requirements of the Gramm, Leach, Bliley Act as implemented by the NAIC Model Privacy of Consumer Financial and Health Information Regulation and applicable state privacy laws and regulations. You further agree that when you are acting on behalf of the Company and learn health information about a person, you cannot disclose that health information to an Affiliate or non-Affiliate unless you first comply with the applicable requirements of the NAIC Model Privacy of Consumer Financial Health Information Regulation and the Standards for Privacy of Individually Identifiable Health Information under the Health Insurance Portability and Accountability Act of 1996 and the applicable implementing regulations and applicable state privacy laws and regulations. You shall return any such information upon request by the Company and, in all events, you shall return all such information to the Company immediately upon termination of this Agreement, and shall retain no copies thereof.

LIMITATION OF AUTHORITY

You have no authority and agree not to:

- (a) Bind the Company by any promise or agreement or incur any debt, expense, or liability whatever in its name or account, contract for or publish any advertising matter or other statement, in the name of, or for, the Company except by and pursuant to specific written authority of the Company.
- (b) Pay or allow or offer to pay or allow, as an inducement to any person to insure, any rebate of premium or consideration or any inducement not specified in the Policies.
- (c) Waive, change, or alter any provisions or conditions in any policy or application.

COMPENSATION

You agree that:

- (a) Subject to the terms and conditions set forth, commissions will be payable to you in accordance with the Policies Compensation Schedule in effect on the effective date of the policies to which they relate.
- (b) The Company reserves the right to discontinue or withdraw any forms and to fix commissions on Policy forms not included in the Policies Compensation Schedule which is now or may hereafter be issued by the Company.
- (c) Upon written notice, the Company may change its Policies Compensation Schedule insofar as it relates to the Policies written after such notice is received by you.
- (d) The amount and time of payment of commissions on replacements, changes, transfers, exchanges, renewals and other special cases shall be governed by the Company rules and regulations.
- (e) If the Company, for any reason, refunds any premium or part of a premium on any policy, any commission paid to you on the amount refunded shall be repaid to the Company.
- (f) You will accept the Company's account with you as conclusive evidence of the state of the account unless objection in writing is received by the Company at its home office within 20 days of the Company's mailing of the account to you. A copy of the said account will be furnished to you once each month.

COMMUNICATION

Executed facsimile or electronic mail transmissions of this Agreement, or of any document executed and delivered in connection herewith, shall be deemed originals and shall be fully enforceable. If facsimile or electronic mail transmissions are exchanged, the parties, shall, if requested by either party, execute and exchange by overnight courier, for retention by the parties, of the originals of any document originally by facsimile or electronic mail within five (5) business days of their exchange of facsimiles or electronic mail. However, the failure of a party to exchange such other originals shall not affect the validity of such facsimile or electronic mail transmission.

APPOINTMENT OF AGENTS

You are authorized to recommend to the Company, the appointment of agents. No agent shall have any authority to represent the Company unless they are appointed by and have a contract with the Company. The contract of such agents may be initiated, cancelled, revised or amended by the Company only. You shall be fully responsible to the Company for the debit balance of all agents in your hierarchy, including the payment of any amounts owed to the Company and the return of any Policy applications, sales materials or supplies of the Company and any other Company documents or information entrusted to them.

On business written by an agent while in your hierarchy, you will be paid the difference, if any, between the commissions stated in the Policy Compensation Schedule attached to this agreement and those specified in the contract between the Company and the applicable agent or agents in your hierarchy.

GENERAL PROVISION

Indebtedness:

- (a) The Company may offset against any compensation due you under the Agreement, or due you by separate agreement from any Affiliate, any amounts now due or subsequently due from you to the Company, or any Affiliate. Any and all amounts due from you shall be a first lien against the compensation due you under this Agreement, prior to any assignment or other agreement you might enter.
- (b) You shall repay any amounts advanced to you. The Company shall not be limited to its right of offset but may at any time demand immediate repayment.

Assignment:

You may not assign this Agreement or the compensation accruing under it, or any interest therein, except with the prior written consent of the Company.

Indemnification:

The PRODUCER will indemnify and hold harmless for all expenses, loss or damage suffered by the Company because of a violation of, or refusal or failure to comply with the terms of this Agreement or with any federal or state laws, rules or regulations, or resulting from unauthorized acts or transactions, errors or omissions by the PRODUCER or the PRODUCER's employees except to the extent that the Company caused, contributed to or compounded such violation, refusal, failure, or other such transactions, acts, errors or omissions or in the event that the Company is determined to be obligated to withhold or pay any income or employment taxes with respect to services rendered by the PRODUCER under this Agreement. Act or transaction includes, but is not limited to fraud, misrepresentations, deceptive practices or negligence by the PRODUCER or the PRODUCER's employees in the sale, submission, delivery or service of the Company's Policies. The Company may negotiate, settle and pay any such claim against the Company.

The Company will indemnify and hold PRODUCER harmless for all expenses, loss or damage suffered by the PRODUCER caused by the Company's errors in preparing, processing, or billing of any policy, except to the extent that the PRODUCER caused, contributed to or compounded such errors. However, the Company will not be liable to the PRODUCER for any legal or other expenses the PRODUCER chooses to incur, solely on its own, in connection with any such error.

TERMINATION

You agree that this Agreement, together with any and all riders and supplements thereto, may be terminated:

- (a) Without cause by the Company or the PRODUCER at will upon thirty (30) days prior written notice to the other.
- (b) Immediately "for cause" which shall include but not be limited to any of the following:
 - 1. Failure to deliver, when due or upon demand, any premiums, monies, records, files, or other property belonging to the Company.
 - 2. Failure to return money to any person where application for the Policy has been rejected by the Company.
 - 3. Failure to comply with any term or provision of this contract.
 - 4. Conducting Policy business in a manner that discredits the Company.
 - 5. Violation of any insurance law or regulation.
 - 6. Dishonesty or fraud.
 - 7. Inducing any Agent of the Company to terminate his or her relationship.
 - 8. Inducing any Policyholder to terminate his or her Policies.
- (c) Upon your death or dissolution

PAYMENTS AFTER TERMINATION

You agree that:

- (a) All rights to commissions or other compensation under the Agreement shall be forfeited should you directly or indirectly cause a policyholder to terminate his or her Policy with the Company.
- (b) If this Agreement is terminated for reasons other than "for cause" or dissolution, and if you have done nothing subsequent to termination to cause your commissions to be forfeited, the Company will continue to pay you or your legal representative the first year and renewal Policy commissions to which you would have been entitled had this Agreement remained in effect.

- (c) If this Agreement is terminated "for Cause" it may, at the option of the Company, result in the loss of all commissions or other compensation otherwise due under this Agreement.

WAIVER/MODIFICATION/ENTIRE AGREEMENT

- (a) **Waivers.**
Failure of the Company to insist upon strict compliance with any of the conditions of this agreement or the rules of the Company shall not be construed as a waiver of any of the conditions or rules, but they shall continue to be in force and effect.
- (b) **Modification.**
This Agreement shall not be modified except by agreement in writing, executed on behalf of the Company by a duly authorized officer of the Company.
- (c) **Entire Agreement.**
This Agreement supersedes all previous contracts, agreements, or oral understandings for the sale of Policies heretofore existing between you and the Company, but shall not affect any obligations of either party under any former agreement. This contract constitutes the entire agreement of the parties hereto. The following schedules and addendum which are attached to this Agreement are herein incorporated and made a part of this PRODUCER Agreement: .

Accepted:

PRODUCER Name (Print) _____

Principal (Print) _____

PRODUCER

Signature _____ Title _____

PRODUCER

Physicians Mutual Insurance Company

By _____
Physicians Mutual Insurance Company

Physicians Life Insurance Company

By _____
Physicians Life Insurance Company



Long Term Care Compensation Schedule

This is an addendum to the Associate Agent Level II Sales Agreement between _____, the Producer and Physicians Mutual Insurance Company, the company, dated _____ and is attached to and forms a part of said agreement. As such this addendum is subject to all the terms and conditions of said agreement. This addendum shall be effective as of _____.

Long Term Care Insurance Policy Forms P145, P146 and P148

Standard LTC Compensation - Excludes MI, DE, IN, WI and PA

Issue Age	Policy Year 1	Policy Years 2 – 10	Policy Years 11+
18 – 54	60%	6%	1%
55 – 59	55%	6%	1%
60 – 64	50%	6%	1%
65 – 69	45%	6%	1%
70 – 74	40%	6%	1%
75 – 79	35%	6%	1%
80+	25%	6%	1%

Endorsed Franchise Group Discounts:

- 5% Discount (P145, P146, P147 and P148) - Commission will be reduced 4 percentage points in policy years 1–10. IN commissions will be reduced 7 percentage points in year 1 and 3.5 percentage points in years 2-6. WI commissions will be reduced 10 percentage points in year 1 and 2.5 percentage points in years 2-6
- 10% Discount for P146 and P148 only - Call for commission information.

Limited Pay Options (10 pay, 20 pay, Paid to 65):

- Commissions paid for policy year one will be the same as non-limited pay options with no renewals paid years 2+. May not applicable in MI, DE, IN, WI and PA.

Home Health Care Payment (P147):

- Commissions will be reduced by **25 percent** for all policy years. Applies to all states

Waiver of Premium

- Commissions will not be paid while a policy is on waiver of premium. Applies to all states

MICHIGAN

P145, P146 and P 148

Issue Age	Policy Year 1	Policy Years 2 – 3	Policy Years 4 - 10	Policy Years 11+
18 – 54	60%	6%	6%	1%
55 – 59	55%	6%	6%	1%
60 – 64	50%	6%	6%	1%
65 – 69	29%	29%	1%	1%
70 – 74	26%	26%	1%	1%
75 – 79	23%	23%	1%	1%
80+	17%	17%	1%	1%

Limited Pay Options (10 Pay, 20 Pay and Paid to 65)

Issue Age	Policy Year 1	Policy Years 2 – 3	Policy Years 4+
18 – 54	60%	0%	0%
55 – 59	55%	0%	0%
60 – 64	50%	0%	0%
65 – 69	22%	22%	0%
70 – 74	19%	19%	0%
75 – 79	16%	16%	0%
80+	10%	10%	0%



DELAWARE

P145, P146 and P 148

Issue Age	Policy Year 1	Policy Years 2 – 10	Policy Years 11+
18 – 54	25%	13%	1%
55 – 59	25%	12%	1%
60 – 64	25%	12%	1%
65 – 69	25%	10%	1%
70 – 74	25%	10%	1%
75 – 79	25%	8%	1%
80+	25%	8%	1%

Limited Pay Options (10 Pay, 20 Pay and Paid to 65)

Issue Age	Policy Year 1	Policy Years 2 – 6	Policy Years 7+
18 – 54	25%	6%	0%
55 – 59	25%	6%	0%
60 – 64	25%	6%	0%
65 – 69	25%	3%	0%
70 – 74	25%	3%	0%
75 – 79	25%	1%	0%
80+	25%	1%	0%

INDIANA

P145, P146 and P 148

Issue Age	Policy Year 1	Policy Years 2 – 6	Policy Years 7+
18 – 54	38%	20.00%	0%
55 – 59	35%	18.50%	0%
60 – 64	32%	17.00%	0%
65 – 69	28%	15.00%	0%
70 – 74	25%	13.50%	0%
75 – 79	22%	12.00%	0%
80+	15%	8.50%	0%

Limited Pay Options (10 Pay, 20 Pay and Paid to 65)

Issue Age	Policy Year 1	Policy Years 2 – 6	Policy Years 7+
18 – 54	24%	13.0%	0%
55 – 59	21%	11.5%	0%
60 – 64	19%	10.5%	0%
65 – 69	17%	9.5%	0%
70 – 74	15%	8.5%	0%
75 – 79	12%	7.0%	0%
80+	8%	5.0%	0%

WISCONSIN

P145, P146 and P 148

Issue Age	Policy Year 1	Policy Years 2 – 6	Policy Years 7+
18 – 54	60.0%	15.00%	0%
55 – 59	55.0%	13.75%	0%
60 – 64	50.0%	12.50%	0%
65 – 69	45.0%	11.25%	0%
70 – 74	40.0%	10.00%	0%
75 – 79	35.0%	8.75%	0%
80+	25.0%	6.25%	0%



Limited Pay Options (10 Pay, 20 Pay and Paid to 65)

Issue Age	Policy Year 1	Policy Years 2 – 6	Policy Years 7+
18 – 54	36.0%	9.0%	0%
55 – 59	33.0%	8.25%	0%
60 – 64	30.0%	7.50%	0%
65 – 69	26.0%	6.50%	0%
70 – 74	23.0%	5.75%	0%
75 – 79	20.0%	5.00%	0%
80+	13.0%	3.25%	0%

PENNSYLVANIA

P145, P146 and P 148

Issue Age	Policy Year 1	Policy Years 2 - 10	Policy Years 11+
18 – 54	40%	6%	1%
55 – 59	40%	6%	1%
60 – 64	40%	6%	1%
65 – 69	40%	6%	1%
70 – 74	40%	6%	1%
75 – 79	35%	6%	1%
80+	25%	6%	1%

Limited Pay Options (10 Pay, 20 Pay and Paid to 65)

Issue Age	Policy Year 1	Policy Years 2 - 10	Policy Years 11+
18 – 54	10%	4%	4%
55 – 59	10%	4%	4%
60 – 64	10%	4%	4%
65 – 69	10%	4%	4%
70 – 74	10%	4%	4%
75 – 79	10%	4%	4%
80+	10%	4%	4%

*Renewal Commissions on limited pay options will be paid as long as premium is received.

COMMISSION GUIDELINES FOR ALL STATES

The chargeback for the return of unearned premium for a death claim shall be 100% of the commissions paid on the premium returned.

New issues that are replacing PMIC LTCI policies will receive renewal commissions only. External replacements will receive the maximum commissions allowable under this Agreement and applicable state law.

I have received, read, understand and agree to the above Addendum.

Date

Producer (Print)

Signature

Title

Physicians Mutual Insurance Company

By _____
Physicians Mutual Insurance Company

CONTRACTING APPLICATION

INSTRUCTIONS * Applications for contracting will not be accepted without this form completed in full.
* Compensation cannot be credited until contracting is completed.

AGENT INFORMATION

FULL NAME (LAST, FIRST, MIDDLE)			COMPANY NAME (IF APPLICABLE)		
HOME ADDRESS	STREET	CITY	COUNTY	STATE	ZIP CODE
BUSINESS ADDRESS	STREET	CITY	COUNTY	STATE	ZIP CODE
18551 Von Karman, Suite 150 Irvine Orange CA 92612					
HOME PHONE NUMBER ()	BUSINESS PHONE NUMBER (949) 863-0700 x113		BUSINESS FAX NUMBER (949) 225-7113		DATE OF BIRTH (MONTH, DAY, YEAR)
SOCIAL SECURITY NUMBER		FEDERAL I.D. NUMBER		E-MAIL ADDRESS	

States to be appointed in: _____ (Include copies of state license(s).)

Products to be appointed for: _____

What products do you currently represent? ☐ Life ☐ Annuity ☐ LTC ☐ Med Supp ☐ Health Ins

BACKGROUND INFORMATION

The information sought in this section is requested solely for the purpose of determining financial responsibility and/or eligibility for insurance license or appointment. A conviction record will not necessarily be a bar to contracting as factors such as age and time of offense, seriousness of violation and rehabilitation are taken into consideration.

Have you ever been convicted of a felony? ☐ Yes ☐ No If Yes, please explain: _____

Have you ever had an insurance license refused, suspended, or revoked? ☐ Yes ☐ No If Yes, please explain: _____

Any judgements or garnishments against you in the past five years? ☐ Yes ☐ No If Yes, please explain: _____

Indebted to general insurance agent or company? ☐ Yes ☐ No If Yes, please explain: _____

Commission should be paid to ☐ Individual or ☐ Company/Corporation

(This **MUST** agree with payee noted on the W-9)

By requesting appointment with Physicians Mutual/Physicians Life Insurance Companies, you agree to allow Physicians Mutual and Physicians Life to contact you for product, company and rate information via phone, fax, e-mail, direct mail and other forms of communication.

PLEASE READ AND SIGN BELOW

The facts set forth in my application for contract are true and complete. I understand that if contracted, false statements on this application shall be considered sufficient cause for contract termination. You are hereby authorized to make any investigation of my personal history and financial and credit record through any investigative or credit agencies or bureaus of your choice.

In making this application for contract, I authorize you to make an investigative consumer report whereby information is obtained through personal interviews with my neighbors, friends or others with whom I am acquainted. This inquiry, if made, may include information as to my character, personal habits and general reputation. I understand that I have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of any such investigative report that is made.

I further understand that any contractual agreement is at will and can be terminated, with or without cause, and without notice, at anytime, at the option of either the company or myself.

SIGNATURE OF AGENT	DATE	B.G.A./A.G.A. NAME	B.G.A./A.G.A. NUMBER
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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"/> Other ▶	<input type="checkbox"/> Exempt from backup withholding
	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. person (including a U.S. resident alien).

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	Date ▶
	U.S. person ▶	

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.

U.S. person. 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.

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.

For federal tax purposes you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or

- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien.

Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments (after December 31, 2002). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester, or
2. You do not certify your TIN when required (see the Part II instructions on page 4 for details), or
3. The IRS tells the requester that you furnished an incorrect TIN, or
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line. Check the appropriate box for your filing status (sole proprietor, corporation, etc.), then check the box for "Other" and enter "LLC" in the space provided.

Other entities. Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Note. You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

Exempt From Backup Withholding

If you are exempt, enter your name as described above and check the appropriate box for your status, then check the "Exempt from backup withholding" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

Exempt payees. Backup withholding is not required on any payments made to the following payees:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),
2. The United States or any of its agencies or instrumentalities,
3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,
4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or
5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,

7. A foreign central bank of issue,
8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,
9. A futures commission merchant registered with the Commodity Futures Trading Commission,
10. A real estate investment trust,
11. An entity registered at all times during the tax year under the Investment Company Act of 1940,
12. A common trust fund operated by a bank under section 584(a),
13. A financial institution,
14. A middleman known in the investment community as a nominee or custodian, or
15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt recipients listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt recipients except for 9
Broker transactions	Exempt recipients 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt recipients 1 through 5
Payments over \$600 required to be reported and direct sales over \$5,000 ¹	Generally, exempt recipients 1 through 7 ²

¹See Form 1099-MISC, Miscellaneous Income, and its instructions.

²However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees; and payments for services paid by a Federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-owner LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter your SSN (or EIN, if you have one). If the LLC is a corporation, partnership, etc., enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at www.socialsecurity.gov/online/ss-5.pdf. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at www.irs.gov/businesses/ and clicking on Employer ID Numbers under Related Topics. You can get Forms W-7 and SS-4 from the IRS by visiting www.irs.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Writing "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt recipients, see *Exempt From Backup Withholding* on page 2.

Signature requirements. Complete the certification as indicated in 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account ¹
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor ²
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee ¹
b. So-called trust account that is not a legal or valid trust under state law	The actual owner ¹
5. Sole proprietorship or single-owner LLC	The owner ³
For this type of account:	Give name and EIN of:
6. Sole proprietorship or single-owner LLC	The owner ³
7. A valid trust, estate, or pension trust	Legal entity ⁴
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

¹ List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

² Circle the minor's name and furnish the minor's SSN.

³ You must show your individual name and you may also enter your business or "DBA" name on the second name line. You may use either your SSN or EIN (if you have one). If you are a sole proprietor, IRS encourages you to use your SSN.

⁴ List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

Direct Deposit of Commissions (ACH Credits)

Authorization Form

By completing and signing this authorization form, I am giving Physicians Life Insurance Company the authority to deposit my commission checks directly into my checking account or savings account.

Full Name (as it appears on the account) _____

Account Number _____

Name of Bank _____

ABA # of Bank _____

Signature of Account Holder _____

Date _____

Select one

☐

Checking Account

☐

Savings Account

Staple a voided check here for checking accounts, or
Staple a saving deposit slip here for savings accounts

Jane Doe	0611
1000 Main St.	Date _____
Anywhere, U.S.A. 10001	
Pay to the	
Order of _____	\$ _____
_____	Dollars
Memo _____	
':256006419': 03020032178 0611	

Transit No.

Account No.

Check No.

ADDENDUM TO AGREEMENT

BETWEEN

PHYSICIANS MUTUAL INSURANCE COMPANY AND PHYSICIANS LIFE INSURANCE COMPANY

AND

This addendum ("Addendum") is made and entered into between **PHYSICIANS MUTUAL INSURANCE COMPANY ("PMIC") AND PHYSICIANS LIFE INSURANCE COMPANY ("PLIC")** (hereinafter collectively referred to as "Company") and _____ (hereinafter referred to as "Business Associate") on this _____ day of _____, 2005.

RECITALS

1. The Company and Business Associate have previously entered into a contractual agreement (the "Agreement") for the provision of certain services. Terms not otherwise defined in this Addendum shall have the meanings ascribed to them in the Agreement.
2. The Company and Business Associate are required by law to revise the Agreement taking into account certain changes in laws as a result of the Standards for Privacy of Individually Identifiable Health Information, 45 CFR Part 160 and Part 164, Subparts A and E (the "Privacy Regulation") under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). This Addendum also incorporates applicable Gramm, Leach, Bliley Act (PL 102-106) ("GLBA") requirements. The Company and Business Associate have agreed to such changes, all in accordance with the term and conditions hereinafter set forth.

NOW, THEREFORE, in consideration of the mutual covenants herein contained in this Addendum, it is hereby agreed as follows:

AGREEMENT

1. **Addendum**. The following language is hereby added to the Agreement as an Addendum:

PRIVACY

- A. **Definitions**. For purposes of this Agreement, the following terms shall have the following definitions:

1. **Health Information**. "Health Information" means information, regardless of medium, that:
 - (a) is created or received by the Company with respect to Covered Lines of Business, and
 - (b) relates to the past, present or future physical or mental health or condition of an Individual, or
 - (c) relates to the past, present or future payment for the provision of health care to an Individual.

Health Information shall also include any information which may be defined as such in the Privacy Regulation, as may be periodically revised by the U.S. Department of Health and Human Services ("HHS"), the U.S. Congress or federal agency.

2. **Protected Health Information.** "Protected Health Information" ("PHI") means, with respect to HIPAA, Health Information, including demographic information (i.e. age and gender), collected from an Individual, that identifies the Individual or could reasonably be believed to identify the Individual.

Protected Health Information for purposes of GLBA would be the same as above except with respect to age and gender. Under GLBA, age and gender are not Health Information.

3. **Individual.** "Individual" shall have the same meaning as the term "individual" in Section 164.501 of the Privacy Regulation and shall generally mean the person who is the subject of PHI and shall include a person who qualifies as a personal representative in accordance with Section 164.502(g) of the Privacy Regulation.
4. **Company.** "Company" shall mean **Physicians Mutual Insurance Company and/or Physicians Life Insurance Company** and include all affiliated covered entities designated in the notice filed pursuant to Section 164.504(d) of the Privacy Regulation.
5. **Business Associate.** "Business Associate" shall mean BGA.
6. **Customer Information.** "Customer Information" means all information about an Individual except PHI.
7. **Covered Lines of Business and Non-Covered Lines of Business.** "Covered Lines of Business" for each of PMIC and PLIC shall refer to those products listed below:

PMIC Covered Lines

Medicare Supplement
Long Term Care
Short term Nursing Home
Specified Disease
Hospital, *Medical and/or Surgical* Indemnity
Hospital, Medical, Surgical Expense Incurred
Dental

PLIC Covered Lines

Medicare Supplement

For purposes of this Agreement, "Non-covered Lines of Business" for each of PMIC and PLIC shall refer to those products listed below:

PMIC Non-Covered Lines

Disability Income
Accident Only

PLIC Non-Covered Lines

Life Insurance
Annuities

(Note: Some lines are not available for solicitation at the time of this Addendum.)

8. **Health Related Products.** "Health related products" shall mean the same as "Covered Lines of Business."

9. Marketing. “Marketing” means a communication about a product or service that encourages recipients of the communication to purchase or use the product or service. However, Marketing does not include a communication that is made by the Company to describe health related products or services that are provided by or included in a plan of benefits, including communications about:

- (a) the Company's participation in a health plan network;
- (b) replacement of, or enhancements to, a health plan; and
- (c) health related products or services available only to a health plan enrollee that add value to, but are not part of, a plan of benefits.

B. Permitted Uses and Disclosures of PHI.

1. Services. Pursuant to this Agreement, Business Associate provides services for the Company that involves the use and disclosure of PHI. Business Associate shall use and disclose PHI only for the purposes permitted under this Agreement. Business Associate may disclose PHI for the purposes authorized by this Agreement only to its employees, subcontractors and agents who are in compliance with Section C(5) below unless otherwise required by law.

2. Business Activities of the Business Associate. Unless otherwise limited herein, the Business Associate may use and disclose PHI in its possession for its proper management and administration and to fulfill any present or future legal responsibilities of the Business Associate provided such uses are permitted under state and federal confidentiality laws, but only if: (i) such disclosure is required by law; or (ii) Business Associate obtains reasonable assurances from the person to whom the PHI is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to such persons, and such person notifies Business Associate of any instances of which it is aware in which the confidentiality of the PHI has been breached.

C. Responsibilities of Business Associate. With regard to the use and disclosure of PHI and Customer Information, the Business Associate hereby agrees that:

- 1. Business Associate may not use or disclose PHI in any manner that would constitute a violation of the Privacy Regulation if used or disclosed by Company;
- 2. Business Associate agrees not to use or further disclose PHI or Customer Information other than as authorized by this Agreement or as required by law;
- 3. Business Associate shall use appropriate safeguards to prevent uses or disclosures of PHI or Customer Information other than as provided for by this Agreement;
- 4. If Business Associate becomes aware of any use or disclosure of PHI not provided for by this Agreement or required by law, it shall report such use or disclosure to Company within three (3) business days of gaining such knowledge;
- 5. Business Associate shall require that its agents, including subcontractors, to whom it provides PHI under this Agreement, agree to the same restrictions and conditions that apply to Business Associates with respect to such information;

6. Within five (5) business days of a request by Company, Business Associate agrees to comply with Company's request to accommodate an Individual's access to his/her PHI. In the event an Individual contacts Business Associate directly about access to PHI, Business Associate will not provide access to the Individual but shall forward such request to Company within two (2) business days of such contact.
7. Within five (5) business days of a request by Company, Business Associate agrees to comply with Company's request to make amendments to PHI. Business Associate shall promptly incorporate any such amendments into the PHI it holds pursuant to this Agreement. In the event an Individual contacts Business Associate directly about making amendments to PHI, Business Associate will not make any amendments to the Individual's PHI but shall forward such request to Company within two (2) business days of such contact.
8. Business Associate shall keep a record of all disclosures of PHI, except as otherwise provided in Section 164.528(a)(1)(i)-(ix) of the Privacy Regulation (a copy of which is attached as Schedule 1), as may be periodically revised or amended.

Business Associate agrees to make information regarding such disclosures of PHI available to Company within five (5) business days of a request by Company. Business Associate shall provide, at a minimum, the following information: (i) the date of disclosure; (ii) the name of the entity or person who receives the PHI, and the address of such entity or person, if known; (iii) a brief description of the PHI disclosed; (iv) a brief statement regarding the purpose and explanation of the basis of such disclosure; and (v) the names of all Individuals whose PHI was disclosed.

9. Business Associate agrees to comply with any other restrictions on the use or disclosure of PHI that Company may from time to time request.
10. Business Associate shall make its internal practices, books and records relating to uses and disclosures of PHI available to Company, or to the Secretary of the U.S. Department of Health and Human Services or its designee, to the extent necessary for purposes of determining Company and Business Associate compliance with the Privacy Regulation.

D. General Rules. Business Associate further agrees that any and all information regarding an Individual that is given by the Individual to the Company on an application for coverage or in a claim as well as any and all additional information regarding the Individual that is disclosed by the Company to Business Associate or its agents (including but not limited to, all PHI and Customer Information):

1. Shall not be disclosed to any entity or person other than the Company;
2. May not be used by the Business Associate or its agents for Marketing any other entity's or person's products or services;
3. Any Customer Information or PHI disclosed by the Company to Business Associate may be used by the Business Associate to provide assistance/customer service (not Marketing) to the Individual.

E. Marketing Rules. Business Associate further agrees that use and disclosure of an Individual's Customer Information and PHI for Marketing purposes is further limited to the following:

1. Customer Information

Customer Information (but not Health Information) relating to PMIC customers may be used for marketing PLIC products. Customer Information (but not Health Information) relating to PLIC customers may be used for marketing PMIC products. For Covered Lines of Business, age and gender are considered Health Information. For Non-covered Lines of Business, age and gender are considered Customer Information.

2. Health Information

A PMIC or PLIC customer owning a Covered Line of Business:

- If Marketing takes place in person, face to face, the customer's PHI may be used to market any PMIC/PLIC product.
- If Marketing takes place by phone, in writing, by E Mail (or any method other than in person, face to face), the PHI of a customer owning a Covered Line of Business product cannot be used to market a Non-covered Line of Business product.

A PMIC customer owning a Non-covered Line of Business:

- That customer's PHI cannot be used to market a PLIC product.

A PLIC customer owning a Non-covered Line of Business:

- That customer's PHI cannot be used to market a PMIC product.

Any PHI of an Individual whose application for a Covered Line of Business is rejected can be used or disclosed only:

- as required by law; or
- to the Individual (and only with the approval of the Company's Home Office); or
- pursuant to the Individual's written authorization.

F. Term and Termination.

- 1. Termination.** Notwithstanding any other provision of this Agreement, Company may immediately terminate this Agreement if Business Associate has materially violated its responsibilities regarding PHI under this Agreement. Company may, at its sole option, before exercising its right to terminate, allow Business Associate an opportunity to provide satisfactory assurances to Company within five (5) business days of notice of such material violation that the violation has been cured and steps taken to prevent its and any other recurrence.
- 2. Change of Law.** Either party may, upon notice to the other, immediately terminate this Agreement upon the enactment of legislation, regulations or other relevant authority or the

issuance of a case or ruling interpreting the same, which necessitates the discontinuance of the business relationship between the parties.

3. **Treatment of PHI and Customer Information Following Termination.** Upon the termination of this Agreement, Business Associate shall return or destroy all PHI and Customer Information and will retain no copies of such information. Prior to doing so, the Business Associate further agrees to recover any PHI and Customer Information in possession of its subcontractors or agents. If the return of PHI and Customer Information or destruction of PHI and Customer Information is not feasible as determined by Company, Business Associate agrees that the provisions of this Agreement shall be extended beyond termination to the PHI, and Business Associate shall limit all further uses and disclosures solely to those purposes that make the return or destruction of the PHI and Customer Information infeasible.

G. Representation and Warranty of Business Associate. Business Associate represents and warrants to Company that:

1. all of its employees, agents, representatives and members of its workforce, whose services may be used to fulfill obligations under this Agreement, are or shall be appropriately informed of the terms of this Agreement and are under legal obligation to Business Associate, by contract or otherwise, sufficient to enable Business Associate to fully comply with all provisions of this Agreement; and
2. it is responsible for compliance with, and its performance of its responsibilities shall at all times comply with, all relevant federal, state and local laws and regulations relating to the performance of its responsibilities under this Agreement including where applicable, but not limited to, all relevant federal or state statutes or regulations intended to comply with the requirements of Title V of GLBA and HIPAA and the Privacy Regulation.

H. Indemnification. Business Associate agrees to indemnify, defend and hold Company and its officers, directors, and employees harmless from any alleged claim, cause of action, liability, damage, penalty, cost or expense, including attorneys' fees, against Company or its officers, directors or employees arising from or in connection with any alleged or actual uses and/or disclosures of PHI or Customer Information in violation of the Privacy Regulation or GLBA by Business Associate or its agents or subcontractors.

Company agrees to indemnify, defend and hold Business Associate and its officers, directors, and employees harmless from any alleged claim, cause of action, liability, damage, penalty, cost or expense, including attorneys' fees, against Business Associate or its officers, directors or employees arising from or in connection with any alleged or actual uses and/or disclosures of PHI or Customer Information in violation of the Privacy Regulation or GLBA by Company.

I. Survival. The responsibilities of Business Associate under this Agreement with respect to GLBA, the Privacy Regulation and HIPAA compliance shall survive termination of the Agreement.

J. Third Parties. Except as expressly provided in the Privacy Regulation or this Agreement, this Agreement does not create any rights in third parties.

K. Inconsistency. If, and to the extent, that any provision of this Addendum is inconsistent with the Agreement, this Addendum shall control. In the event of an inconsistency between the provisions of

this Agreement and the mandatory terms of the Privacy Regulation, as may be expressly amended from time to time by the HHS, the U.S. Congress, or as a result of interpretations by HHS, a court, or another regulatory agency with authority over the parties hereto, the interpretation of HHS, such court or regulatory agency shall prevail. Any ambiguities in this Agreement shall be resolved in a manner which permits the Company to comply with the Privacy Regulation. Where provisions of this Agreement are different from those mandated by the Privacy Regulation, but are nonetheless permitted by the Privacy Regulation, the provisions of this Agreement shall control.

2. **Ratification.** Subject to the alterations and amendments herein contained, Business Associate and Company hereby ratify and confirm the Agreement in all other respects.
3. **Reference to and Effect on the Agreement.** Upon the effectiveness of this Addendum, each reference in the Agreement and in any other documents describing or referencing the Agreement to “this Agreement,” “hereunder,” “hereof,” “herein,” or words of like import referring to the Agreement, shall mean and be a reference to the Agreement as amended by this Addendum.
4. **Execution of Counterparts.** This Addendum may be executed in one or more counterparts, each of which when so executed shall be deemed to be an original and all of which taken together shall constitute one and the same agreement.

IN WITNESS WHEREOF, this Addendum is effective the date first above written.

The Company
PHYSICIANS MUTUAL INSURANCE COMPANY
PHYSICIANS LIFE INSURANCE COMPANY, a
Nebraska corporation

By: _____
Name: _____
Title: _____
Date: _____

Business Associate

_____,
a _____ corporation

By: _____
Name: _____
Title: _____
Date: _____

SCHEDULE 1

RIGHT TO AN ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION SECTION 164.528(a)

Standard: right to an accounting of disclosures of protected health information.

1. An individual has a right to receive an accounting of disclosures of protected health information made by a covered entity in the six years prior to the date on which the accounting is requested, except for disclosures:
 - i. To carry out treatment, payment and health care operations as provided in § 164.506;
 - ii. To individuals of protected health information about them as provided in § 164.502;
 - iii. Incident to a use or disclosure otherwise permitted or required by this subpart, as provided in § 164.502;
 - iv. Pursuant to an authorization as provided in § 164.508;
 - v. For the facility's directory or to persons involved in the individual's care or other notification purposes as provided in § 164.510;
 - vi. For national security or intelligence purposes as provided in § 164.512(k)(2);
 - vii. To correctional institutions or law enforcement officials as provided in § 164.512(k)(5);
 - viii. As part of a limited data set in accordance with § 164.514(e); or
 - ix. That occurred prior to the compliance date for the covered entity.

PRODUCER PROFILE

Please complete this form and return to CPS. We must have a completed and signed form on file.

PRODUCER INFORMATION				
Name		Company/Corporation Name		
Fax		E-Mail Address		
Business Phone		Home Phone		
Business Street Address	Suite	City	State	Zip Code
Home Street Address	Apt. No.	City	State	Zip Code
Mail to? <input type="checkbox"/> Business <input type="checkbox"/> Home		Preferred method of correspondence? <input type="checkbox"/> Mail <input type="checkbox"/> Fax <input type="checkbox"/> E-mail		
Social Security No.		Tax ID No.		
Insurance License No.		Date of Birth – Day/Mo/Year		
Designations (Check all that apply) <input type="checkbox"/> CLU <input type="checkbox"/> CPCU <input type="checkbox"/> ChFC <input type="checkbox"/> RHU <input type="checkbox"/> CFP <input type="checkbox"/> LUTC <input type="checkbox"/> CIC <input type="checkbox"/> Other: _____				
Do you carry E&O insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Yes? Name of carrier?		
Do you assign commissions? <input type="checkbox"/> Yes <input type="checkbox"/> No		Yes? To whom?		
Are you securities licensed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Applicable Licenses? <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 22 <input type="checkbox"/> 24 <input type="checkbox"/> 26 <input type="checkbox"/> 63		
If NASD registered, what is the name of your broker dealer				

Please go to next page

IT IS AGREED by and between CPS Insurance Services (hereinafter referred to as MGA), and the producer whose name appears on page 1 (hereinafter referred to as Producer) that in consideration of MGA's continued goodwill and patronage:

- A. MGA agrees that commission payment, if any, made by MGA to Producer shall be vested in Producer to the same extent that commissions on the same transaction are vested in MGA by applicable insurance company, with the exception of group insurance which may be subject to a Broker of Record direction.
- B. In the event that any commission, premium, or fee paid or credited to Producer must be referenced or returned by MGA to the insurer, MGA is authorized, but not obligated, to make payment on Producer's behalf and will be reimbursed for this payment in full by Producer within thirty (30) days of the date of such payment. If such payment is not made by Producer, then MGA is authorized to debit any commissions which may be due Producer until such obligation has been fulfilled. Producer will also reimburse MGA for any and all costs and expenses (including reasonable attorney's fees) incurred by MGA in collection of any such sums from Producer.
- C. Producer agrees to hold MGA harmless and indemnify MGA against any and all liability, loss, damages, judgements, costs or expenses of any nature, type or kind (including reasonable attorney's fees) incurred by MGA or imposed upon MGA as a result of any allegedly wrongful or tortuous act or omission on part of the Producer.
- D. The Agent/Company consents to the transmission of information, whether personal, commercial or of an advertising nature, by way of the fax number or email address set forth herein, or other fax numbers or email addresses of the agent/company.

In the event of litigation to determine the respective rights, duties and/or obligations of the parties under this agreement, the prevailing party shall be entitled to reasonable attorney's fees.

Print Name

Sign Name

Date

Thanks for doing business with CPS Insurance Services!