Selling Agent Application

Agent Information

Type of Appointment Requested: ❑ Individual ❑ Partnership ❑ Corporation

A. Applicant Information

Applicant			Date of Birth
Business Name		Agent Email Address	
Business Address			County
City		State	Zip Code
Business Phone Number		Cell Number	
Agency Taxpayer I.D. -	SS# - -	Use the following for tax purposes (check one) ❑ TIN # ❑ SS#	License Number of entity to be appointed

B. Compensation Payable Contact Information (If other than above)

Note: Compensation can only be paid to the person/entity printed on the required NYS license.

c/o			
Address			
City		State	Zip
Phone	Fax	Email	

C. General Agency Information

General Agency Name	HealthPass General Agency Code	General Agent Rep.

D. Officers and Directors

List all officers and directors and give information requested below. If sub-licensee, check box(es) and list before other officers and directors.

Name (Last, First, M.I.)		Date of Birth
Title of Officer	SS# - -	Check here if sub-licensee ❑
Name (Last, First, M.I.)		Date of Birth
Title of Officer	SS# - -	Check here if sub-licensee ❑

E. Partner Carrier Appointment Requirements (Benefits Exchange only)

Anthem Broker ID
Oxford Broker ID

NOTE: You must be appointed, and up-to-date, with all our partner medical carriers on a direct basis to receive any monthly HealthPass compensation. Failure to do so will result in your monthly commission to be placed on hold which could lead to loss of commission. Please contact our Licensing Department at 212-252-8010 or email sales@healthpass.com to request Carrier Agent Agreement(s).

F. Background Information (to be supplied by Agent)

1. Has anyone named on this application ever been known by any name other than the one on the first page of this application?
   ☐ No ☐ Yes

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

3. Has anyone named on this application ever been fined or formally disciplined by any insurance entity?
   ☐ No ☐ Yes

4. Has anyone named on this application ever been charged or investigated, in any capacity whatsoever, with financial irregularities, misconduct or fraud by any insurer, financial institution, employer or other party?
   ☐ No ☐ Yes

5. Has the applicant ever had its agency appointment terminated for cause or for any of the above reasons?
   ☐ No ☐ Yes

6. Other than traffic infractions or "Youthful Offender" adjudications, has anyone ever been convicted of a crime?
   ☐ No ☐ Yes

Note: If you answered "Yes" to any of the above questions, please list all relevant dates, places, states and names on the lines provided below. 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.

X _____
Signature of Applicant (Selling Agent) Date

As part of the procedure for processing this application for credentialing with HealthPass, an investigative report may be made. Such a report will be confidential and will be used for purposes of evaluating the applicant's qualification to become credentialed. 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 credentialing of the above applicant.

X _____
Authorized Signature of General Agent Date

G. Mandatory Direct Deposit

I hereby authorize HealthPass to initiate direct deposit to my bank for my monthly compensation payments. If I make changes to my banking arrangements, I understand that I must notify HealthPass to effect the changes for payment collection. All changes must be reported 20 days prior to the effective date of the change. _____
initials

Please check one - ☐Checking Account ☐Savings Account
Bank Name _____
Routing Number/ABA Number_____
Account Number_____

Please attach a voided check for direct deposit.

NOTE: The Selling Agent Application must be completed and provided with a copy of your current State of New York Department of Financial Services - Life, Accident & Health License, Credentialed Agent Agreement, Business Associates Agreement, W9, and voided check to your General Agent or:
HealthPass Licensing Department
112 W 34th Street, 18th Floor
New York, NY 10120
or email sales@healthpass.com