GoldenCare
Planning Today For A Secure Tomorrow
AN INTEGRITY COMPANY

CONTRACTING MADE EASY

As a special service to our valued agents, GoldenCare will take all necessary steps to get you contracted with as many carriers as you wish!

Print to complete by hand or take advantage of fillable fields. If using fillable fields, once all entries are made, print and **sign where required**.* Provide your signature in the CENTER of the box on the Required Signature page. (*Keep a copy for your records!*) **

Once submitted, be on the lookout for email(s) containing **contracting invite links** from SuranceBay or other contracting portal entities working with our carriers. If email(s) do not appear in your inbox within a week, remember to check your Junk folder.

To expedite processing, we must receive a copy of your agent license(s).

*** Important Note:**
Electronic signatures utilizing styled font cannot be accepted. Acceptible signatures include wet signatures or handwritten signatures affixed with electronic tools.

Submit finished, signed contract by:

SECURE FILE UPLOAD
https://goldencareagent.com/contracting-upload/

Fax:
866-863-8608

Email:
contracting@goldencareusa.com
Protect your information using encryption!

Mail: **GoldenCare**
10700 Old County Rd 15, Suite 450
Plymouth, MN 55441

On the Agent Data Sheet, note some carriers require Errors & Omissions (E & O) coverage. *Great News*: If you enroll in the 2023/2024 E & O plan, and submit 1 qualifying application written between April 1, 2023 and April 1, 2024, you will receive a discount on your 2024/2025 enrollment! It's never too late to enroll. Coverage is pro-rated for the quarter you are covered.

For policy details, qualifying business, and/or to enroll online, click on "Discounted E & O" within the *Tools* tab of www.goldencareagent.com. And while you are on our website, check out the many programs and services we offer!

** *Please save a copy of this packet in order to retain data entered in the fillable fields.*

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AGENT DATA SHEET FOR BROKERS

10700 Old County Road 15, Suite 450, Plymouth, MN 55441
contracting@goldencareusa.com
Fax: 866-863-8608 | Phone: 800-842-7799

Agent's Full Name (as it appears on State License) _____ ◯ Male ◯ Female
Date of Birth _____ Social Security # _____ Are you a U.S. Citizen? ◯ Yes ◯ No
Driver's License Number and state of issuance: _____
State & License Number(s) for requested appointment (***Provide copy of license(s)***):
Resident License: _____ Non-Resident License(s): _____
Designated Beneficiary and Relationship _____
Name of Upline Manager (*if applicable*) _____ **INTERNAL ONLY:** _____ RefCode
Check type of contract you are requesting: ◯ Individual ◯ Agency/Officer ◯ Licensed Only (*paid by Upline Manager*)
If Agency/Officer, submit agency license(s) with contracting and provide the following: Tax ID _____
Agency name: _____ Officer title: _____
Type of Agency: ◯ S-Corporation ◯ C-Corporation ◯ Partnership ◯ Other _____
E-Mail Address (*required*) _____

Residence Address - *Please do not use P.O. Boxes*

Street _____
City _____ State _____ Zip _____
Phone _____ Mobile _____
Number of Years at the address above? _____
Within the last 5 years, have you lived in a different state/county?
◯ No ◯ Yes (*provide history details on a separate sheet*)

Business Address

Street _____
_____
City _____
State _____ Zip _____
Phone _____ Fax _____

INDICATE CARRIER(S) WITH WHICH TO BE CONTRACTED - *(Please select at least one)*

☐ **ACE** — MedSup
☐ **Aetna & Affiliates**
❑ MedSup/Life/Health ❑ MA
☐ **Aflac** — MedSup/Final Expense
☐ **Allstate** — MedSup
☐ **Cigna**
❑ MedSup ❑ MA
☐ **Guarantee Trust Life**
❑ Advantage Plus ❑ CHS ❑ MedSup
☐ **Humana**
❑ MedSup ❑ MA
☐ **Lumico/Elips** — MedSup
☐ **ManhattanLife**
❑ OmniFlex STC & HHC ❑ MedSup ❑ FE
☐ **Medica***
❑ Medicare ❑ Individual
☐ **Mutual of Omaha and Affiliates**
❑ MedSup/Dental ❑ Living Promise ❑ PDP*
☐ **National Guardian Life (NGL)** — Funeral Trust
☐ **SureBridge** — Dental/Vision/Hearing
☐ **United Health*†** — MedSup/MA
☐ **Other**: _____

* *$1,000,000 E & O Required*
† *Requires UHC-Specific Background Questions*

❑ ***Unless this box is checked*, Medicare Supplement elections will be advanced where possible.**
NOTE: An advance with Mutual of Omaha & Affiliates will impact *all health products*, except AccDeath.

PRIORITY HANDLING FOR NEW BUSINESS

Is new business imminent OR submitted w/ contracting? ◯ Yes ◯ No
If yes, please disclose the following details: Sign Date: _____
Carrier: _____
Product: _____
Client Name: _____
Client Resident State: _____ App Sign State: _____
Splitting Agent Name: _____

CURRENT E&O INFORMATION *(Provide copy of contract)*

Coverage Provided By _____
Policy Number _____
Coverage Amount per occurence _____
Total Amount of Coverage/Aggregate _____
Effective _____ Expiration _____

Agent Signature _____
Date _____

REQUIRED SIGNATURE

Please sign in the center of the box below.

AGENT NAME: _____ DATE: _____

(PRINT NAME HERE)

SIGNATURE AUTHORIZATION

PLEASE READ THIS AUTHORIZATION, SIGN IN THE CENTER OF THE BOX BELOW AND SUBMIT THIS FORM BY FOLLOWING THE INSTRUCTIONS PROVIDED ON THE COVER PAGE.

I, _____, hereby authorize and direct GoldenCare USA LLC, National Independent Brokers LLC and American Independent Marketing, LLC (each an "Agency" and together the "Agencies"), each insurance carrier with which they contract (each a "Carrier" and together, the "Carriers") and any third party operating a portal used for contracting ("Third Parties," and together with the Agencies and Carriers, collectively, the "Authorized Parties") to affix or append a copy of my signature, as set forth below, to any and all required signature fields on forms, agreements and other related instruments ("Appointment Forms") of any Carrier requested by me in writing, for purposes of, and in furtherance of, obtaining such Carrier's appointment and authorization permitting me to sell its products (the "Initial Purpose"), and to continue, on my behalf thereafter, all activity relevant to post-appointment administrative and sales-related processes for purposes of, and in furtherance of, selling such Carriers' products (the "Secondary Purpose" and together with the Initial Purpose, the "Purposes"), including affixing my signature to any and all required signature fields on forms, agreements and other related instruments in furtherance of the Secondary Purpose ("Administrative Forms"). My signature will not be used by the Authorized Parties for any purpose other than the Purposes.

In connection with the Purposes of becoming authorized to sell and selling Carrier insurance products, the Authorized Parties shall be permitted to create a personal User ID and Password (which the Authorized Parties will provide to me upon my request), complete and submit all such Appointment Forms and Administrative Forms to achieve the foregoing Purposes (each of which will be furnished to me upon my request following its execution for my records to the extent in the possession of an Agency, or, if not in the possession of an Agency, each of which may be provided to me upon Agency's commercially reasonable efforts to obtain such Appointment Forms and Administrative Forms from the requisite Carrier). By my signature below, I hereby agree that execution on the foregoing Appointment Forms and Administrative Forms of any Carrier by the Authorized Parties shall be binding upon me and have the same effect as if I directly executed such forms, agreements or instruments. I hereby release, indemnify and hold harmless the Authorized Parties against any and all claims, demands, losses, damages, and cause of action, including expenses, costs and reasonable attorneys' fees which may be sustained or incurred as a result of its reliance on any of the Appointment Forms or Administrative Forms bearing my signature pursuant to the authorization granted hereunder.

By my signature below, I certify that the supporting background information I have submitted to the Authorized Parties, including as provided to you on the attached Background Information Questionnaire, is complete and correct to the best of my knowledge. I understand that such information is valid for 90 days from the date hereof, and that after such period, I may be contracted to update any applicable information.

I hereby acknowledge that I have had the opportunity to consult with independent legal counsel regarding any questions I may have about this authorization page prior to my execution thereof.

REQUIRED SIGNATURE:
PLEASE SIGN YOUR NAME IN THE CENTER OF THE BOX BELOW.

Please use BLACK ink.