

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. Acceptable 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.

**Your Success Is Our Priority
It Is A Pleasure To Be Of Service To You**

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 occurrence _____

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.

