OBM[SM] Broker Services Agreement

I. GENERAL INFORMATION

ALL brokers must sign this OBM Broker Services Agreement to sell OBM products. See reverse side.

The OBM Broker Services Agreement is not a broker contract to sell insured specialty products. All OBM brokers must be appointed by United Healthcare Insurance Company to sell the OBM plans, which include insured dental and vision products. For more information about becoming an appointed broker, please visit ***www.oxfordbenefitmanagement.com***. You can also call 888-200-1154 to receive copies of OBM forms and/or materials via fax or mail.

The OBM Broker Services Agreement allows OBM and brokers to share critical information needed to perform services on behalf of groups that purchase OBM prepackaged product offerings, which include insured and discount products offered by third-party vendors. It also provides an explanation of the limitations of liability by OBM. This document is not intended as a replacement for the United Healthcare Insurance Company Request for Appointment Form.

Oxford Benefit Management Inc. (OBM) is an employee benefits distribution company that packages a unique selection of third-party vendor products through general agents and insurance brokers. OBM is a wholly owned subsidiary of Oxford Health Plans, LLC.

OBM organizes specialty benefit packages through distribution agreements with selected vendors. Under these agreements, vendors provide discount and insured products, which are included in the OBM benefit packages.

II. TERMS & CONDITIONS

- OBM acts as a distributor of selected vendor products only and is not responsible for the underwriting or benefit administration related to a specific product. OBM is not responsible for benefit design, insured product pricing or claims management including payment of claims or denial of claims, lost payments or cancelled policies. OBM assumes no liability for the acts, omissions or negligence of any OBM vendor.
- Broker represents that all state licenses are updated and on file with the appropriate regulatory authority and that the broker is in good standing with the state in which he/she is licensed.
- This service agreement between OBM and the broker is valid for as long as the broker remains licensed and is in good standing by the state in which he/she has been licensed and is automatically cancelled if the broker's license elapses or is rescinded.
- There is no vesting of commissions. Commissions or service fees are payable only if the broker services the group and is considered the agent of record by the customer.
- This agreement represents the entire agreement and may only be modified in writing.

III. SERVICES TO BROKERS

- OBM provides access to prepackaged specialty products for groups.
- OBM, through its third-party administrator (TPA), provides a simple to administer, easy to manage process for groups, to include providing one bill for all services provided in a benefit package.
- OBM shall provide to the broker, on a monthly or otherwise regular basis, a statement setting forth commissions and/or service fees earned and payable to broker along with an accounting of charges to the broker's commission account.
- OBM has contracted with a TPA to provide administrative services to all OBM customers. TPA shall invoice customers, collect payments, and send out notices of termination and late payments. All questions related to these issues must be directed to the TPA by calling OBM directly at 888-200-1154.
- OBM may modify products and benefit packages at anytime without prior notices to brokers.

IV. RESPONSIBILITIES TO OBM

- Broker agrees to the terms and conditions of this contract, and guidelines established by OBM. Broker shall be considered an independent contractor for purposes of this contract. As an independent contractor, broker reserves the right to exercise independent judgment as to the time, place and manner of soliciting applications for insurance.
- No other provision of this contract nor any rule of regulation of OBM shall be construed to abridge this right or create the relationship of employer and employee.
- Broker has no authority except as stated in this contract. No other authority may be implied from the authority expressly granted herein.
- The broker will be required to be appointed by United Healthcare Insurance Company in order to be eligible for commissions and/or service fees associated with the sale of OBM benefit packages.
- Broker agrees not to use the name and marks of OBM or any OBM third-party vendors in any communications or marketing material without OBM's prior written consent.

V. COMMISSIONS

- Commissions shall be paid to brokers only after the appropriate premium has been paid in cash and accepted by OBM.
- No commission shall be payable on any premium paid in advance until the due date of the premium and then only if OBM retains such premium.
- If OBM returns a premium on a policy, for any reason whatsoever, the broker shall repay OBM on demand any commissions or service fee received on such premium.
- Commissions on policies reinstated after 90 days of the due date on the first premium in default are payable to the original broker only if the policy is wholly reinstated through the efforts of the original broker.
- No commission shall be payable on any premium paid to OBM via a third-party collection agency. Credit memos applied to a group invoice as a write-off or bad debt write-off are not eligible for commissions and/or service fees.
- Health Network America (HNA), our TPA, pays commissions on behalf of third-party vendors for all OBM benefit packages sold through brokers and general agents. Commissions are based on total product fees received by HNA each month. Such commissions shall be paid to broker only after the appropriate product fees are remitted in cash to HNA and accepted by OBM. Selling brokers receive a flat 8% commission on the total product fee received in any given month for each benefit package. All commissions are paid monthly for as long as the broker holds the broker of record (BOR), and/or the group remains an OBM customer.

VI. DISCLOSURE OF INFORMATION

- All sensitive and confidential information gained in the course of working with OBM will be held in confidence and in accordance with state regulations and all HIPAA mandates that are in effect at present or at any future time. Broker agrees to enter into all necessary agreements with OBM, HNA or any other vendor approved by, in order to maintain HIPAA requirements.
- Any, and all marketing materials, group reporting data, financial information or correspondence between OBM and the broker must remain confidential between OBM, approved vendors, HNA, the broker and the customer. OBM retains the rights and ownership of all OBM marketing materials and forms.

Please Note: Oxford Benefit Management, Inc. acts as the distribution company for products by third-party vendors including UnitedHealthcare Dental, Spectera, LifeEra and UnitedHealth Allies. The UnitedHealthcare Dental PPO Plan, the UnitedHealthcare Dental Trust Plan and Spectera, Inc. are underwritten by United Healthcare Insurance Company, Hartford, Connecticut (except in New York), United Healthcare Insurance Company of New York, Hauppauge New York (New York only). OBM does not underwrite or administer these products and bears no risk on any product offered. All information within this document is subject to change.

VII. TERMINATION

- Broker or OBM may immediately terminate this Agreement, with or without cause, by notice sent by ordinary mail to the last known address of the other party.
- Upon termination, broker shall immediately deliver to OBM or its representative all rate manuals, policyholder record cards, application forms, letters, written correspondence with customers, clients and representatives of OBM, records, sales materials, equipment and all other supplies and materials connected with, authorized or printed by and belonging to OBM or any of its affiliates.
- If broker appointment with United Healthcare Insurance Company providing insured products terminates, this agreement shall immediately terminate consistent with this section.

ALL brokers must sign this OBM Broker Services Agreement to sell OBM products. Mail or fax to:

Oxford Health Plans
Attn: OBM Licensing & Commissions
48 Monroe Turnpike
Trumbull, CT 06611
FAX: 203-459-3296

VIII. REQUIRED INFORMATION

Name

Company

Address

City | State | Zip

Phone Number | E-Mail Address

Broker License Number | State of License

IX. ADMINISTRATION

Amendments/Assignments No modifications or amendment/assignments of this contract nor any assignment of commissions payable hereunder shall be valid unless approved in writing by an authorized officer of Oxford.

Severability If any provision of this contract is found to be legally or otherwise unenforceable, the remainder of this contract shall not be affected and shall remain fully enforceable.

Forbearance Forbearance or neglect by OBM to insist upon performance of this contract shall not constitute a waiver of its rights and privileges.

Kevin Hill, *EVP Sales* | Broker Signature

Date | Date

UnitedHealthcare
A UnitedHealth Group Company

REQUEST FOR APPOINTMENT

Sales Office/Health Plan location: OBM **Please Type or Print**

Name ______________________ DOB: ____________ S.S.#: __________

Affiliated Agency ______________________________ FED ID #: __________

W-9 Form must be attached

Street (and PO Box if applicable) ______________________ Phone #: __________

Fax#: __________

City State Zip

☐ Business
☐ Residence

Residence Address ______________________________

Street ______________________________

City State Zip

License number (Attach a copy along with W-9) Individual ______________ Agency ______________

If an Agency, please have an Officer complete the form and attach his/her license copy.

I request appointment to represent the following entities:

☐ United Healthcare Insurance Company ☐ Local Healthcare Plan ______________

Employment History (past 5 years-attach additional pages if necessary)

Employer Name: ______________ Title: __________ Phone #: __________

Address: ______________ From: __________ To: __________

Employer Name: ______________ Title: __________ Phone #: __________

Address: ______________ From: __________ To: __________

Has your license ever been suspended or revoked? If yes, please explain: ______________

Have you ever been convicted of a Felony or crime, such as those involving fraud, deceit or misrepresentation? If yes, please explain:

____

Are you an employee of a UHG Sales Office? ☐ No ☐ Yes

**How do you wish to assign your commission(s)? ☐ No ☐ Yes (If SSN#, attach the agent's individual license and complete the w-9 on behalf of agent. If TID#, attach licenses for both the agent and the agency, and complete the w-9 on behalf of agency)

If assigning commissions to the Tax Identification #, the boxed section MUST be completed.

If appointed, I hereby authorize any of the companies that I am appointed to represent to pay commissions to the assignee below:

Agency Name: ______________________ FED ID #: ______________

Agency Address: ______________________________

____

I authorize payment to the assignee of all such commission, without notice to me, and without requiring any further authorization from me. Payment to the assignee shall constitute a full and complete release and discharge of any company liable for payment of such commissions. I hold any of the companies that I am appointed to represent harmless from any and all claims for commissions which are subject to this assignment.

Signature: ______________________ Your Title: ______________ Date: __________

A routine inquiry may be made in accordance with state requirements which will obtain information concerning your character, general reputation, personal characteristics and mode of living. This inquiry may include information regarding employment, financial and/or criminal history. Upon your written request, additional information as to the nature and scope of the report, if one is made, will be provided. Your signature below acknowledges your understanding of this procedure and authorizes us to do any background investigation we deem necessary to allow you to be appointed to represent any of United HealthCare's affiliated insurers and/or Health Maintenance Organizations and/or Metropolitan Life Insurance Company.

If appointed to represent any of the above companies, you understand that you will be considered an independent contractor, and not an employee of such company(ies). This application and any attachments become a part of your agent's file with any of the companies that you are appointed to represent.

Date: ______________________ Applicant's Signature: ______________________

#7812

IMPORTANT TAX DOCUMENT
SUBSTITUTE FORM W-9

Request for Taxpayer Identification Number

We are in the process of updating our provider records. As part of that process we are requesting that you complete this Substitute Form W-9. We are required by law to obtain this information from you when making a reportable payment to you. If you do not provide us with this information, your payments may be subject to 28% federal income backup withholding. Also, if you do not provide us with this information, you may be subject to a $50 penalty imposed by the Internal Revenue Service under Section 6723 of the Internal Revenue Code.

PLEASE NOTE: INFORMATION REPORTED ON LINES 1-3 MUST BE CONSISTENT WITH DATA REGISTERED WITH THE IRS AND SOCIAL SECURITY ADMIN.

Note to US Resident Aliens who formerly were Nonresident Aliens: If there is a tax treaty between the U.S. and your country and it contains a "saving clause" to exempt certain types of income from U.S. tax even after you have become a Resident Alien, and you want to claim that exemption, fill out all of this form AND attach a page showing: 1. The treaty country 2. The treaty article about the income 3. The article number for the "saving clause" 4. The type and amount of income that qualifies for the saving clause 5. Facts that provide a sufficient explanation of why the saving clause applies.

1. Taxpayer Name ____________________

(**To whom the check is payable. Actual recipient of payment -** This MUST BE the **legal entity name registered with IRS** if a corporation or partnership; the **business owner's name** if a sole proprietor.)

Doing Business as: DBA____________________

(A division name, if a corp. or the name of the business, if a sole proprietor)

2. Taxpayer Address ____________________

____

3. Taxpayer Identification Number (TIN) (Complete only one line A-F)

a. Individual ____________________
(List Taxpayer's Soc. Sec #)

b. Sole Proprietorship ____________________
(List business owner's Soc. Sec # or employer identification number)

c. Corporation ____________________
(List employer identification number)

d. Partnership ____________________
(List employer identification number)

e. Tax Exempt Entity ____________________
(List employer identification number) Please attach a copy of your tax-exempt status letter from the IRS.

f. Other - Please Explain ____________________

g. Effective date ____________________

4. Certification:

Under penalties of perjury, I certify that:

a. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me).

b. I am not subject to backup withholding because: (i) I am exempt from backup withholding, or (ii) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (iii) the IRS has notified me that I am no longer subject to backup withholding, and

c. I am a U.S. person (including a U.S. resident alien). If you are a foreign person, use the appropriate Form W-8. See Pub.515, Withholding of Tax on Nonresident Aliens and Foreign Corporations.

____
(Print name)

5. Signature and Today's Date ____________________ ____________________
(Signature) (Date)

6. Daytime Phone Number and Email Address (______)____________________ **Email:** ____________________

If you have any questions, call the 1-888-641-9147 regarding your taxpayer identification number or the backup withholding requirement. Please complete this form and forward to: **UNITEDHEALTH GROUP 9NB, Attn: Producer Credentialing – 450 Columbus Blvd. Hartford, CT. 06103**

The following are for internal use only

Current Legal Entity Name of Payee____________________

Current TIN on Account____________________

Account Number____________________