

AGENT / AGENCY APPLICATION FOR APPOINTMENT

Agent/ Agency Information (please print):

List the state(s) in which you are requesting appointment? *Please attach copies of licenses.*

Are you a resident of this state? Yes No
 Please check appropriate item: Partnership Individual Sole Proprietor
 Corporation Other (please identify)

National Producer Number (NPN):

Social Security Number:

Federal Employer Identification Number:

Provide SSN & FEIN if appointing both agent and agency

Full Name of Agent or Agency *(Legal name must correspond with SSN or FEIN)*

Business Mailing Address *(Include Post Office Box if applicable):*

City:		State:	Zip Code:		
State of Incorporation <i>(If Applicable):</i>	Date of Incorporation <i>(If Applicable):</i>	Length of time at this location <i>(if less than 5 years, please include on a separate sheet of paper a list of all locations):</i>			
Date of Birth	Phone Number	Fax Number	E-mail Address		
Resident Mailing Address <i>(If Applicable)</i>		Resident County			
Resident City	Resident State	Resident Zip Code	Resident Phone Number	Resident Fax Number	
Beneficiary	Beneficiary Relationship	Beneficiary Phone Number / Address			

NOTE: A minimum of \$500,000 specific and \$500,000 aggregate E&O coverage is required.
 E&O coverage Amount of _____ E&O carrier _____ Copy of E&O declaration page or Certificate
 Yes No E&O coverage: _____ & policy#: _____ of Insurance included with application Yes No

The following questions are applicable to the agent/ agency/ corporation/ partnership and to each of the partners, members, directors, officers or agents individually. If the answer is "Yes" to any of these questions, provide complete details on a separate sheet of paper. To the best of your knowledge:

- | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>A. Have you or any of the partners, directors, officers or agents within this corporation / partnership ever been fined, reprimanded, sanctioned or been the subject of a consent decree in any state for a violation of insurance laws, HMO regulations or other administrative regulations?
 Yes No</p> <p>B. Have you or any of the partners, members, directors, officers or agents within this corporation / partnership ever been refused license to sell Insurance/HMO, or has a license to sell Insurance/HMO ever been suspended or revoked by any state?
 Yes No</p> <p>C. Have you or any of the partners, members, directors, officers or agents within this corporation / partnership ever been convicted of a crime, whether felony or misdemeanor, other than a minor traffic violation?
 Yes No</p> | <p>D. Have you or any of the partners, members, directors, officers or agents within this corporation / partnership ever been employed by an Insurance / HMO company, or another organization providing for or assisting with administration of health care or other employee benefits, where the employment contract was terminated or non-renewed because of allegations of wrongdoing?
 Yes No</p> <p>E. Have you or any of the partners, members, directors, officers or agents within this corporation / partnership ever surrendered any insurance or HMO license, whether voluntary or involuntary?
 Yes No</p> <p>F. Are you or any of the partners, members, directors, officers or agents within this corporation / partnership currently a named party in any lawsuit?
 Yes No</p> <p>G. Have you or your company ever declared bankruptcy, had a lien placed against you or your company, been a judgment debtor or had any other problems with your or your company's credit history?
 Yes No</p> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

If you answered Yes to any of the questions (A to G), please give details and the current status. (Attach any pertinent documentation.)

I hereby certify that I have read and understand the items on this form and that my answers are true and complete to the best of my knowledge. I have been advised the Company may conduct investigations in connection with my request to represent the SWHP in the solicitation of SWHP and ICSW products as described in the Producer Agreement. I hereby consent to the company requesting and obtaining all information as discussed in this paragraph and for all such reports to be requested by and provided to the SWHP.

I understand that a routine inquiry may be made as a requirement for state appointment. If applicable, the SWHP may obtain reports from a consumer reporting agency, an investigation report or inquiries from a State Insurance Department. Any information that the SWHP obtains about me will be treated as confidential.

FAIR CREDIT REPORTING ACT - As part of its regular procedures, the SWHP may obtain an investigative consumer report. It may deal with character, reputation, personal traits and lifestyle. It may involve personal interviews with friends, neighbors and associates.

I understand I have the right to make, within a reasonable amount of time, a written request for details on the name and address of the agency making the report. I further understand that, depending on the state law, subjects of an investigative consumer report may have the right to: 1) request that they be interviewed in connection with the making of the report; and 2) receive a copy of the report, upon request. My signature below constitutes my agreement and authorization to the above.

In signing this application I certify that I have not been convicted of any criminal felony involving dishonesty or breach of trust or been convicted of an offense under section 1033 of the Violent Crime and Law Enforcement Act of 1994. I further agree to immediately inform Scott & White Health Plan of any conviction of the types described in the preceding sentence.

I understand that if any of the information I provided is found to be incorrect or incomplete, it may be grounds for non-appointment or my immediate termination at the discretion of the SWHP.

Applicant's Signature
(Agent or Agency Officer if applying for Agency Appointment)

FMO Name

Print Name

Title

Date

Licensing Contact Name

Licensing Contact Phone Number

FOR INTERNAL USE ONLY

Submitted By:

SWHP Representative Name:

Telephone Number:

SWHP Number:

Region:

**SCOTT AND WHITE HEALTH PLAN
INSURANCE COMPANY OF SCOTT AND WHITE**

AGENT CONTRACT

THIS AGREEMENT, effective on the date specified at the signature portion of this Agreement ("Effective Date") is made between Scott and White Health Plan and Insurance Company of Scott and White, Texas corporations, hereinafter collectively referred to as "SWHP", and _____ hereinafter referred to as "Agent", to describe the terms and conditions under which Agent shall provide certain services for SWHP. For services rendered on or after the Effective Date, this Agreement supersedes and replaces any existing agreements between the parties, except where otherwise noted, relating to commissions and other compensation arrangements for Agent services.

WHEREAS, Scott and White Health Plan holds a valid Certificate of Authority granted by the Texas Department of Insurance to operate a health maintenance organization (HMO) within its service area in Central Texas, illustrated by Attachment D, and provides products in the individual and Large and Small Employer HMO markets; and

WHEREAS, Insurance Company of Scott and White is a wholly owned corporation of Scott and White Health Plan that is licensed as a Health Insurance Company by the Texas Department of Insurance in the State of Texas, and provides individual and Large and Small Employer Major Medical products and Individual indemnity and income products; and

WHEREAS, Agent is duly licensed by the State of Texas to solicit and sell HMO and health insurance products and desires to sell and market SWHP's products to new clients;

NOW, THEREFORE, in consideration of the foregoing and of the mutual promises and undertakings herein and intending to be legally bound hereby, the parties agree as follows:

**SECTION 1
Definitions**

- 1.1 Benefit Plan:** Benefit Plans are the products identified in Attachment B that SWHP authorizes Agent to market to Clients.
- 1.2 Business Day:** Monday through Friday, 8:00am to 5:00pm, Central Standard Time, with the exception of national holidays as recognized by federal law.
- 1.3 Client:** An individual or an employer group, solicited by Agent pursuant to this Agreement which meets all eligibility and underwriting criteria and is approved by SWHP for enrollment under a Benefit Plan.
- 1.4 Commissions:** The payments due Agent for the services performed by Agent for a Client. The Agent's Commissions shall be paid as provided for in Section 4 and Attachment A.
- 1.5 Contract Premium Charges:** The total annual or monthly premium charges required of and collected from Clients for all Benefit Plan products.
- 1.6 Contract Month and Contract Year:** The calendar month or year as determined from the effective date of the Client under a Benefit Plan.
- 1.7 Existing Business:** A Client that already had, as of the effective date of this contract, comprehensive health coverage through SWHP.

- 1.8 New Business:** A Client that does not at the time of application have, or has not anytime within the previous 12 months prior to application had comprehensive health coverage through SWHP.
- 1.9 Payor:** Entity authorized by SWHP that has the financial responsibility for payment of certain services provided by Agent under the terms of this Agreement.
- 1.10 Subscriber:** A contract holder, a policyholder or an eligible employee, as defined in the Benefit Plan, who is properly enrolled for coverage under the Benefit Plan. The Subscriber is the person (who is not a dependent) on whose behalf coverage under the Benefit Plan is provided.

SECTION 2

General Responsibilities of Agent

2.1 Licensing:

- a. Before any services are provided under this Agreement, Agent shall provide to SWHP proof of a valid Texas license for Agent to perform services under this Agreement.
- b. Agent shall comply with SWHP's appointment process and comply with continuing education requirements and other requirements necessary to maintain Texas licensure to perform services under this Agreement.
- c. Agent shall promptly provide a copy of Agent's renewed Texas licenses. Agent acknowledges that failure to maintain Texas licensure or promptly provide proof of licensure to SWHP shall constitute a material breach of this Agreement and shall be cause for immediate termination.

2.2 Limitation on Authority: Agent shall not:

- a. bind coverage;
- b. accept any applicant;
- c. misrepresent or omit important facts in any application;
- d. modify or waive any Benefit Plan or any terms regarding enrollment, coverage or benefits;
- e. distribute any advertising, circulars or promotional literature except such materials provided to Agent by SWHP;
- f. represent that Agent have authority on behalf of SWHP or Payor;
- g. have any authority except as explicitly provided in this Agreement.

2.3 Prohibited Actions: Agent shall in no way misrepresent SWHP or its products or services. Agent is specifically prohibited from:

- a. altering any proposal;
- b. approving evidence of insurability or improperly binding or committing SWHP on any risk;
- c. reinstating any terminated or non-renewed evidence of coverage, certificate of coverage of policy;
- d. using any advertising or other material related to SWHP or its products without prior approval by SWHP.

A list of SWHP's Benefit Plans Agent is authorized to sell is shown on Attachment B.

2.4 Training: Agent shall complete SWHP's initial training within sixty (60) days of the effective date of this Agreement as well as participate in ongoing training to assure Agent's compliance with SWHP's marketing and enrollment policies and procedures. Such training shall include, but is not limited to:

- a. open enrollment training;
- b. sales call training;
- c. routine evaluation of Agent's performance under this Agreement;
- d. other training as may be required by SWHP from time to time.

In order to remain an appointed agent of SWHP, Agent is expected to attend scheduled agent training workshops and receive an annual certification from SWHP.

2.5 Solicitation:

- a. Agent shall solicit enrollment of Clients.
- b. Agent shall submit to prospective Clients proposal information or documents in a form and upon such terms as are approved in advance by SWHP.
- c. No term of such proposal, including premium amounts, may be altered except upon the prior written approval of SWHP.
- d. Agent shall accurately and completely record information required by SWHP for enrollment of Clients under a Benefit Plan and submit such information to SWHP.
- e. Agent shall acquire all additional quote information, as requested by the SWHP's Sales and Account Representatives.
- f. Agent shall work through their assigned Sales Representative to obtain premium rate proposals, including small group premium proposals.
- g. Agent shall promptly present the proposal to a prospect/Client.

2.6 Acceptance for Enrollment:

- a. SWHP shall have the sole right to accept or reject any prospective Client submitted for enrollment by Agent based on underwriting and enrollment policies established by SWHP.
- b. In no event shall any prospective Client be eligible to receive health services under a Benefit Plan unless, and until, accepted by SWHP with such effective date as determined by SWHP.
- c. Agent will review applications, enrollment forms, applications for contracts and similar or related documents solicited by Agent and promptly forward completed documents and initial premium payment to SWHP within two (2) Business Days of completion.

2.7 Servicing of Clients:

- a. Agent shall deliver and explain to Clients, the initial administrative forms, such as billing and enrollment materials and subsequent renewal forms. This function may be performed in conjunction with SWHP's Account Representative.
- b. Agent shall provide on-going services to existing customers to possibly include conducting enrollment meetings, handling routine inquiries and conducting renewal presentations as approved in advance by SWHP.
- c. The Agent shall also, by acceptance of this Agreement, use their best efforts to maintain the relationship between SWHP and the Client, and to maintain full cooperation by the Client and their employees, if applicable, with SWHP.
- d. Agent has no property or other interest whatsoever in any contract between SWHP and Client.
- e. Agent is not authorized to receive any SWHP funds except the initial premiums for SWHP Products, and Agent is not authorized to deduct commissions or any other amounts from any initial premiums Agent may collect. Any funds that Agent does receive for or on behalf of SWHP shall be received and held by Agent in a fiduciary capacity, shall be separately accounted for, shall not be commingled by Agent with personal funds of Agent or other business accounts managed or owned by Agent, and shall be remitted to SWHP promptly but in no event later than five (5) calendar days from the date of receipt.
- f. Agent agrees to furnish SWHP with all information necessary to enable SWHP to comply with its obligation under this Agreement and state, federal and HIPAA law, including, but not limited to, information regarding Agent relationship with Client.

2.8 Marketing Materials: Upon request, Agent may obtain from SWHP such marketing and enrollment materials as are necessary for solicitation of Clients. Agent shall not use any marketing materials or other information regarding SWHP or Payor to the competitive advantage of any competitor of SWHP or Payor. Agent shall not distribute any materials that have not been furnished or approved by SWHP including, but not limited to:

- a. Letterhead, business cards, and written materials containing SWHP's name or logo;
- b. Descriptive literature and sales aids of all kinds, including but not limited to: circulars, leaflets, booklets, illustrations, software, and form letters;
- c. Printed and published material, audio-visual materials, and or descriptive language used in direct mail, newspapers, magazines, radio and television scripts, prepared sales talks or presentations, billboards, telephone directory listings, websites and similar displays.

Agent shall return all such materials to SWHP immediately upon termination of this Agreement.

2.9 Books and Records:

- a. Agent shall maintain adequate books and records in accordance with the industry standard and applicable law.
- b. SWHP, during regular business hours, and upon reasonable notice shall have access to and the right to audit all information and records related to services rendered by Agent pursuant to this Agreement.
- c. Unless a longer time period is required by applicable law, SWHP shall have access during the term of this Agreement and for six (6) years following its termination.

SECTION 3 Responsibilities of Agent under HIPAA

Agent agrees to execute and comply with the requirements of the attached HIPAA Business Associate Agreement. Failure to comply with the terms of the BAA is a material breach of this Agreement.

SECTION 4 Payment

- 4.1 Payment to Agent:** For services performed under this Agreement, Payor shall pay Agent according to Attachment A, Commission Schedule. For New Business, Agent shall be compensated for products issued to a Client which has identified the Agent as the Agent of Record. For Renewal Business initially generated as New Business by Agent, Agent shall be compensated according to Attachment A, Commission Schedule. If Agent replaces Existing Business, Agent shall not be compensated. Any compensation payable to Agent for duties other than those set forth in Section 2 shall be made pursuant to a separate agreement. SWHP shall not pay additional compensation or recoup payments more than fifteen (15) months from when a payment dispute arises. SWHP will not split commissions between two Agents.
- 4.2 Retroactive transactions:** To the extent that retroactive terminations and adds are made by an employer group Client, such retroactive transactions will be reflected in the premiums statements submitted to and paid by that Client, and will therefore be reflected in the commission paid pursuant Attachment A, Commission Schedule. In the event that retroactive transactions are made after an employer group Client has terminated coverage with SWHP, Agent agrees to reimburse SWHP any overpayment of commissions, and SWHP agrees to pay Agent any underpayment of commissions, paid to Agent due to the retroactive transactions.
- 4.3 Taxes:** Payor shall take no deduction for federal income tax, social security or other regulatory taxes. Agent shall be solely responsible for reporting and payment of any taxes of any type, including social security taxes, workers' compensation taxes or costs, unemployment compensation taxes or costs or any other similar taxes, costs or charges or any other taxes or charges related to Agent's receipt of compensation and performance of services under this Agreement. Agent shall indemnify and hold SWHP and Payor harmless from any such taxes or charges. This Section shall survive any termination of this Agreement.

SECTION 5 Agent of Record

- 5.1 Designation of Agent of Record:** An Agent of Record is the Agent designated by a Client to serve as its insurance agent and that SWHP may compensate under the terms of this Agreement. Unless otherwise stipulated by the Client, Agent shall be considered the Agent of Record for all Clients enrolled by Agent.
- 5.2 Change of Agent of Record:** The Client may change its Agent of Record at any time for any reason in accordance with applicable law and the following provision are not intended to limit this right in any way.
- 5.3 Written request from Client:** In its sole discretion, SWHP will recognize a request to change an Agent of Record only if it is in writing and is signed by an individual authorized to bind the Client, and not from Agent or any other person. If a Client asks SWHP to change its Agent of Record, SWHP will determine the effective date of the change in its sole discretion.
- 5.4 Termination Events:** Upon termination of Agent under Paragraph 7.3 of this Agreement, SWHP will no longer recognize Agent as any Client's Agent of Record.

SECTION 6 Insurance and Indemnification

- 6.1 Insurance:** Agent shall maintain general liability, professional liability and errors and omissions insurance policies or bonds in amounts and in forms standard and adequate for Agent's business but not less than \$500,000 per occurrence. Agent shall provide proof of such insurance every two (2) years and shall immediately give written notice to SWHP in the event of any termination, cancellation or material change in such insurance. Written notice shall be sent to SWHP's Licensing Department at the address shown in the signature portion of this Agreement.
- 6.2 Indemnification:** Agent indemnifies and holds SWHP, its directors, officers and subscribers harmless from any claims, liability, judgments, damages or costs, including reasonable attorneys' fees, asserted or awarded against or incurred by SWHP, its directors, officers and subscribers as a result of any act, error or omission of Agent or other personnel of Agent.

SECTION 7 Term and Termination

- 7.1 Term:** This Agreement shall commence on the Effective Date and shall continue for one (1) year and shall automatically renew for successive one (1) year terms unless terminated pursuant to this Section.
- 7.2 Termination without Cause:** This Agreement may be terminated without cause by either party to this Agreement upon thirty (30) days prior written notice to the other party. However, termination of this Agreement shall be subject to the following provisions:
- a) In the event this Agreement is terminated by SWHP or Agent without cause, Payor shall pay Commissions until Agent is no longer Agent of Record with the Client or at such time Client is no longer enrolled with the SWHP, until the Client's next renewal.
 - b) As described in Section 10.9.
- 7.3 Termination with Cause:** This Agreement may be terminated with cause by either party to this Agreement immediately with written notice provided to the other party. However, immediate termination of this Agreement shall be limited to the following conditions and subject to the following provisions:
- a) SWHP shall consider "material breach" under the terms of this Agreement to be actions that include, but are not limited to: unprofessional conduct; failure to give SWHP at least thirty (30) days notice prior to moving Client's business to a competitor of SWHP's; disparaging or derogatory comments about SWHP made by Agent to SWHP's customers, potential customers, Clients, Subscribers, Providers, Payors, other Agents, or to any individual with a business interest in SWHP, and may immediately terminate this Agreement on such grounds. In addition, Agent, acting as a Business Associate, acknowledged that its failure to cure any violation of HIPAA regulations of this Agreement shall also be

considered a material breach of this Agreement and that SWHP may therefore immediately terminate this Agreement and any other contract between SWHP and Agent.

- b) In the event this Agreement is terminated by SWHP with cause, no Commissions shall be payable to the Agent following the date of such termination. For the purposes of this Agreement, “with cause” shall mean any material breach in the terms of this Agreement.
- c) In the event Agent is no longer duly licensed pursuant to applicable law, SWHP may immediately terminate this Agreement, and this shall be deemed termination “with cause.” In addition, if Agent is suspended or disciplined by any state or federal regulatory authority or is reprimanded in any way in connection with performance of his or her duties as a Agent, SWHP reserves the right, in its sole discretion, to immediately terminate this Agreement. Such termination shall be deemed termination “with cause” under the terms of this Agreement. No Commissions shall be payable to Agent following the date of such termination. Agent shall immediately notify SWHP if any of the conditions contained within this paragraph 7.3 occur.

SECTION 8 Reservation of Rights by SWHP

8.1 SWHP specifically reserves the right to:

- a) Discontinue or withdraw from sale any product, certificate, contract, marketing materials, or special marketing concept in any jurisdiction.
- b) Modify, change, or amend any certificate, policy, contract or premium rate.
- c) Review Agent’s accounting records.
- d) Cease doing business in any market segment in any jurisdiction.
- e) Modify its business practices or operations in any other manner deemed appropriate by SWHP.

SECTION 9 Resolution of Disputes

9.1 Good Fair Negotiation Required: SWHP and Agent agree to work together in good faith to resolve any disputes arising under this Agreement. If after at least forty five (45) days following the date one party sent written notice of the dispute to the other party the dispute is not resolved, any party may pursue resolution of the dispute by other means.

SECTION 10 Miscellaneous

10.1 Agreement as Confidential: SWHP and Agent shall treat this Agreement as confidential and shall not disclose its terms to any third party; except that SWHP may disclose certain terms to Payors, and may file the form of this Agreement with any federal or state regulatory entity as may be required by applicable law.

10.2 Relationship of the Parties: The sole relationship between SWHP and Agent is that of independent contractors and nothing in this Agreement or otherwise shall be deemed or construed to create any other relationship, including one of employment, joint venture or Agent.

10.3 Compliance with State, Federal and HIPAA Regulations: Agent acknowledges that SWHP, and/or its affiliates, may be government contractors. The information to which Agent may have access to pursuant to this Agreement may contain confidential protected health information (PHI). Accordingly, Agent agrees to comply with all applicable state, federal and HIPAA regulations.

10.4 Amendment: Except as otherwise provided in an Attachment, SWHP may amend this Agreement upon at least thirty (30) days prior written notice to Agent. Any amendment to the Attachments shall apply to Clients that are effective or renewed under a Benefit Plan on or after the effective date of such amendment.

10.5 Assignment: SWHP may assign all or any of its rights and responsibilities under this Agreement to any entity controlling, controlled by, or under common control with SWHP. Agent acknowledges that persons

and entities under contract with SWHP may perform certain administrative services under this Agreement. Agent may not assign any of its rights, responsibilities or Commissions payable under this Agreement to any person or entity without the prior written consent of SWHP.

- 10.6 Entire Agreement:** This Agreement, including all Attachments hereto, contains the entire understanding of the parties.
- 10.7 Data Rights:** Agent acknowledges that it has no ownership rights in Confidential Information, PHI or any other data provided to it by SWHP pursuant to the terms of this Agreement or any Obligations to SWHP.
- 10.8 Ownership Interest:** The references to each party shall be deemed to include any parent, subsidiary or affiliate (1) in which the party has an equity or other ownership interest, (2) in which such party is a member, or (3) which controls, is controlled by or is under common control with such party.
- 10.9 Amending Attachments:** The attachments to this Agreement may be amended from time to time by SWHP. If the parties do not agree to the terms of the amended attachments, this Agreement may be terminated upon sixty (60) days prior written notice to the other party subject to the provisions of Section 7.2.

THE EFFECTIVE DATE OF THIS AGREEMENT IS _____.

Scott and White Health Plan
Insurance Company of Scott and White
Address: 2401 S. 31st St.
Temple, TX 76508

Agent: _____

Agent address: _____

Signature: _____

Signature: _____

Print Name: _____

Print Name: _____

Title: _____

Title: _____

Date: _____

Date: _____

Tax ID # _____

Attachment A
Medicare Products
 Agent under FMO

1. Commission due to authorized agents who sell a Medicare plan will be paid based upon the CMS approved "Fair Market Value Amounts" defined in the Marketing guidelines published by CMS each plan year.

Product	Counties	New*	Renewal**
Medicare Cost Plan H-4564	Anderson, Austin, Bastrop, Bell, Blanco, Bosque, Brazos, Burleson, Burnet, Cass, Cherokee, Coke, Coleman, Colorado, Concho, Coryell, Crockett, Falls, Fayette, Freestone, Gregg, Grimes, Hamilton, Harrison, Henderson, Hill, Irion, Kimble, Lampasas, Lavaca, Lee, Leon, Limestone, Llano, Madison, Marion, Mason, McCulloch, McLennan, Menard, Milam, Mills, Rains, Reagan, Robertson, Runnels, Rusk, San Saba, Schleicher, Smith, Somervell, Sterling, Sutton, Tom Green, Travis, Van Zandt, Waller, Washington, Williamson, and Wood	\$408	\$204
MA-PD H-8237 (HMO)	Collin, Dallas, Ellis, Johnson, Rockwall, and Tarrant counties	\$408	\$204

*New commission rate is based on the CMS approved amount each year for new sales.

**Renewal commission rate is based on the CMS approved renewal rate each year.

2. Agents must complete CMS approved training and testing required by Scott & White Health Plan in addition to becoming appointed before commissions will be paid. If an agent does not meet testing requirements each year commission, will not be paid for sales within that contract year.

Scott & White Health Plan

Agent

By: _____
 Marinan Williams
 Interim President/CEO

 Print Name

By: _____
 Signature

Title: _____

Date: _____

Date: _____

Attachment B
Benefit Plans

As referenced in Attachment A, the following is a list of Benefit Plans offered by Scott & White Health Plan and the Insurance Company of Scott and White that an Agent is authorized to sell:

SeniorCare Medical and Rx Plans (Cost Plan)

Vital Traditions MA-PD

Any authorization to add to the number or type of products an Agent is authorized to sell may be made by an officer of SWHP. Such change must be made in writing on the form attached hereto as Attachment B-1.

ATTACHMENT A
COMMISSION SCHEDULE

Agent under FMO

1. Individual commissions to authorized agents will be paid monthly based upon **paid** premiums.

Writing Agent Payout					
Product	Year 1	Year 2	Year 3	Year 4	Year 5+
SWHP Individual HMO	6%	6%	6%	6%	6%
ICSW Individual PPO	6%	6%	6%	6%	6%
ICSW Cancer Income Protection	20%	7%	7%	3%	3%
ICSW Gap Income Protection	20%	7%	7%	3%	3%
ICSW Accident Income Protection	20%	7%	7%	3%	3%
ICSW Hospital Indemnity	20%	7%	7%	3%	3%
ICSW Short Term Medical	10%	-	-	-	-

2. Group commissions to authorized agents will be paid monthly based upon **paid** premiums and amounts will be based upon the following table:

Group	
Group Size	Agent Commission
2 - 50	5.5%
51 - 99	5.0%

Scott & White Health Plan

Agent

By: _____
Marinan Williams
Interim President/CEO

Print Name

By: _____
Signature

Title: _____

Date: _____

Date: _____

ATTACHMENT B

Benefit Plans

As referenced in Attachment A, the following is a list of benefit plans offered by Scott & White Health Plan that the Agent is authorized to sell:

- All fully insured individual products (QHP plans on or off Exchange)
- All Large and Small Group fully insured commercial HMO products, including Point of Service Rider
- All fully insured ICSW major medical products
- All fully insured Consumer Directed products
- Individual ICSW Income and Indemnity products
- Self-funded TPA products

Any authorization to add to the number or type of products the Agent is authorized to sell may be made only by an officer of SWHP. Such change must be made in writing on the form attached hereto as Attachment B-1.

Scott & White Health Plan

Agent

By: _____
Marinan Williams
Interim President/CEO

Date: _____

Print Name

By: _____
Signature

Title: _____

Date: _____

**BUSINESS ASSOCIATE AGREEMENT
SCOTT AND WHITE HEALTH PLAN AND [BA]**

This Business Associate Agreement (“BA Agreement”), effective [REDACTED], 20__ (the “Effective Date”), is entered into by and between [BA] (“Business Associate”) and Scott and White Health Plan, as agent for and on behalf of its affiliates which are covered entities (collectively, “Covered Entity”).

RECITALS

A. Business Associate and Covered Entity are engaged in a business relationship whereby Covered Entity obtains from Business Associate, and Business Associate sells or provides to Covered Entity, certain products and/or services (“Business Relationship”);

B. As part of this Business Relationship, Business Associate performs or assists in performing a function or activity on behalf of Covered Entity that involves the use and/or disclosure of Protected Health Information (as defined in 45 C.F.R. 160.103).

C. The parties desire to enter into this BA Agreement regarding the use and/or disclosure of Protected Health Information as required by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), the Standards for Privacy of Individually Identifiable Health Information (the “Privacy Rule”) and the Standards for Security of Electronic Protected Health Information (the “Security Rule”) promulgated thereunder, and the Health Information Technology for Economic and Clinical Health Act (Division A, Title XIII and Division B, Title IV, of the American Recovery and Reinvestment Act of 2009, Pub. L. 111-5) (the “HITECH Act”), and the regulations implementing the HITECH Act.

NOW, THEREFORE, for and in consideration of the representations, warranties and covenants contained herein, and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties hereto agree as follows:

AGREEMENT

1. Terms Used. Terms used but not otherwise defined in this BA Agreement shall have the same meaning given to such terms in HIPAA, the HITECH Act, or any implementing regulations promulgated thereunder, including but not limited to the Privacy Rule and the Security Rule. For the avoidance of doubt, the term Protected Health Information shall include Electronic Protected Health Information.

2. Permitted Uses and Disclosures of Protected Health Information. Except as otherwise limited in the Business Relationship or this BA Agreement, Business Associate may use and/or disclose Protected Health Information to perform the functions, activities, or services for or on behalf of Covered Entity as specified in the Business Relationship provided that such use and/or disclosure (a) would not violate the Privacy Rule or Security Rule if done by Covered Entity, (b) is reasonably limited to the minimum

necessary information to accomplish the intended purpose of the use or disclosure, (c) is in compliance with each applicable requirement of 45 C.F.R. § 164.504(e), and (d) is in compliance with the HITECH Act and its implementing regulations. All other uses and/or disclosures not authorized by the Business Relationship or this BA Agreement are prohibited.

3. Responsibilities of Business Associate with Respect to Protected Health Information. With regard to the use and/or disclosure of Protected Health Information, Business Associate hereby agrees:

a. not to use and/or disclose Protected Health Information other than as permitted or required by the Business Relationship or this BA Agreement or as Required By Law;

b. to use appropriate safeguards to prevent the use and/or disclosure of Protected Health Information other than as provided for by the Business Relationship or this BA Agreement;

c. to comply with the Security Rule provisions set forth in 45 C.F.R. Part 164, Subpart C, including provisions relating to Security Standards General Rules (45 C.F.R. § 164.306), Administrative Safeguards (45 C.F.R. § 164.308), Physical Safeguards (45 C.F.R. § 164.310), Technical Safeguards (45 C.F.R. § 164.312), Organizational Requirements (45 C.F.R. § 164.314) and Policies and Documentation (45 C.F.R. § 164.316), and to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information which Business Associate creates, receives, maintains, or transmits on behalf of Covered Entity;

d. to report to Covered Entity any Security Incident or potential Breach of Unsecured Protected Health Information of which it becomes aware, in the following times and manners:

(1) any actual, successful Security Incident shall be reported to Covered Entity in writing within two (2) business days of Business Associate's discovery of such actual, successful Security Incident;

(2) any attempted, unsuccessful Security Incident of which Business Associate becomes aware shall be reported to Covered Entity in writing, on a reasonable basis at the written request of Covered Entity but in no event more often than on a quarterly basis; and

(3) any potential Breach of Unsecured Protected Health Information shall be reported to Covered Entity in writing within two (2) business days of Business Associate's discovery of such potential Breach of Unsecured Protected Health Information,

and (in any case) any such report shall include the identification of each Individual whose Unsecured Protected Health Information has been, or is reasonably believed by Business

Associate to have been, accessed, acquired, used or disclosed during any such Security Incident or potential Breach, together with such other information regarding the Security Incident or potential Breach as is known to Business Associate at the time such report is made (such as the type of Protected Health Information involved in the event, the nature of the information accessed, acquired or disclosed, etc.) or promptly thereafter as such other information becomes available;

e. to notify Covered Entity in writing within two (2) business days of any use and/or disclosure of Protected Health Information that is not provided for by the Business Relationship or this BA Agreement;

f. to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this BA Agreement or by its subcontractor or agent in violation of the agreement described in Section 3.h., or as the result of any Security Incident or potential Breach, using mitigation actions that are disclosed to Covered Entity in advance and authorized by Covered Entity, all at the sole cost and expense of Business Associate;

g. to work cooperatively with Covered Entity in connection with Covered Entity's investigation of any potential Breach and in connection with any notices Covered Entity determines are required as a result, and to refrain from giving any notice itself unless Covered Entity expressly agrees in advance and in writing to Business Associate giving notice and to the form, content and method of delivery of such notice, all at the sole cost and expense of Business Associate;

h. to ensure that all subcontractors and agents that create, receive, maintain or transmit Protected Health Information on behalf of Business Associate agree in writing to substantially the same restrictions and conditions that apply to Business Associate with respect to such Protected Health Information;

i. to provide access (at the request of, and in the time and manner reasonably designated by, Covered Entity) to Protected Health Information in a Designated Record Set to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 C.F.R. § 164.524 (this provision shall be applicable only if Business Associate has Protected Health Information in a Designated Record Set) and to notify Covered Entity of any requests for access it receives from an Individual within two (2) business days of receipt;

j. to make any amendment(s) (at the request of, and in the time and manner reasonably designated by, Covered Entity) to Protected Health Information in a Designated Record Set that Covered Entity directs pursuant to 45 C.F.R. § 164.526 (this provision shall be applicable only if Business Associate has Protected Health Information in a Designated Record Set) and to notify Covered Entity of any amendment requests it receives from an Individual within two (2) business days of receipt;

k. to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528;

l. to provide to Covered Entity, in a time and manner reasonably designated by Covered Entity, information collected in accordance with Section 3.k. of this BA Agreement, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528 (and HITECH Act § 13405(c) when such requirements are effective as to Covered Entity);

m. to the extent Business Associate is to carry out an obligation of Covered Entity under the Privacy Rule provisions set forth at 45 C.F.R. Part 164, Subpart E (any such obligation to be carried out only when so directed by Covered Entity pursuant to the Business Relationship or this BA Agreement), to comply with the requirements of the Privacy Rule that apply to Covered Entity in the performance of such obligation;

n. to make its internal practices, books, and records relating to the use and/or disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available to Covered Entity, or at the request of Covered Entity, to the Secretary of the Department of Health and Human Services or his/her designee, in a time and manner designated by Covered Entity or the Secretary, for purposes of determining Covered Entity's and/or Business Associate's compliance with the Privacy Rule and/or Security Rule; and

o. if Business Associate knows of a pattern of activity or practice by its subcontractor or agent that constitutes a material breach or violation of Business Associate's obligations under this BA Agreement or of the agreement described in Section 3.h. of this BA Agreement, (i) to give written notice of such pattern or practice to Covered Entity within two (2) business days of its discovery; (ii) to take reasonable steps to cure the breach or end the violation; and (iii) if Business Associate determines that such steps appear to have been unsuccessful, to promptly terminate the subcontractor's or agent's creation, receipt, maintenance, or transmittal of Protected Health Information on behalf of Business Associate and to give Covered Entity written notice of such determination and termination.

4. Responsibilities of Covered Entity with Respect to Protected Health Information.
If deemed applicable by Covered Entity, Covered Entity shall:

a. provide Business Associate with the notice of privacy practices that Covered Entity produces in accordance with 45 C.F.R. 164.520 as well as any changes to such notice;

b. notify Business Associate in writing of any change in, or revocation of, permission by Individual to the use and/or disclosure of Protected Health Information, if

such changes affect Business Associate's permitted or required uses and/or disclosures; and

c. notify Business Associate in writing of any restriction to the use and/or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 C.F.R. 164.522.

5. Specific Use and Disclosure by Business Associate. Except as otherwise limited in the Business Relationship and this BA Agreement, Business Associate may:

a. use Protected Health Information for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate;

b. disclose Protected Health Information for the proper management and administration of Business Associate, provided that the disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom Protected Health Information is disclosed that it will remain confidential and be used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of Protected Health Information has been breached; and

c. use Protected Health Information to provide Data Aggregation services to Covered Entity as permitted by 42 C.F.R. 164.504(e)(2)(i)(B).

6. Term and Termination.

a. Term. The Term of this BA Agreement shall be effective as of the Effective Date and shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such Protected Health Information, in accordance with Section 6.c. below.

b. Termination for Cause. Covered Entity may immediately terminate the Business Relationship and/or this BA Agreement if Covered Entity determines that Business Associate has breached a material term of this BA Agreement.

c. Effect of Termination.

(1) Except as provided in paragraph (2) of this Section 6.c., upon termination of the Business Relationship and/or this BA Agreement, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This Section 6.c.(1) shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

(2) In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide in writing to Covered Entity notification of the conditions that make return or destruction infeasible. Upon mutual written agreement of the Parties that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this BA Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

7. Indemnification. Business Associate agrees to indemnify and hold harmless Covered Entity and its affiliates and their respective current and former officers, directors, members, employees and agents (collectively, “Indemnitees”), from and against any liability, claim, action, loss, cost, damage or expense (including reasonable fees of attorneys and experts) incurred or suffered by Indemnitees, to the extent that such liability, claim, action, loss, cost, damage, expense or fee is attributable to or incurred as a result of an unauthorized use or disclosure of Protected Health Information by Business Associate or its subcontractor or agent; an acquisition, access, use, or disclosure, by Business Associate or its subcontractor or agent, that constitutes a Breach or Security Incident; any breach of this BA Agreement by Business Associate; or any breach of the agreement described in Section 3.h. of this BA Agreement by Business Associate’s subcontractor or agent.

8. Miscellaneous.

a. Application and Incorporation. As of the Effective Date, this BA Agreement supersedes any preexisting business associate agreement between the parties and automatically amends any preexisting contract or relationship — written or unwritten, formal or informal — between Business Associate and Covered Entity, and this BA Agreement does and will apply to, and be deemed incorporated into, all present and future contracts and relationships — written or unwritten, formal or informal — between Business Associate (including its officers, directors, employees, independent contractors, and agents) and Covered Entity regardless of any specific reference to this BA Agreement or lack thereof.

b. Amendment. The Parties agree to take such action as is necessary to amend this BA Agreement from time to time as is necessary for Covered Entity and Business Associate to comply with the requirements of the Privacy Rule, the Security Rule, HIPAA, the HITECH Act and its implementing regulations. Notwithstanding the forgoing, if Covered Entity and Business Associate have not amended this BA Agreement to address a law or final regulation that becomes effective after the Effective Date and that is applicable to this BA Agreement, then upon the effective date of such law or regulation (or any portion thereof) this BA Agreement shall be amended automatically and deemed to incorporate such new or revised provisions as are necessary for this BA Agreement to be consistent with such law or regulation and for Covered Entity and Business Associate to be and remain in compliance with all applicable laws and regulations. Except as provided in this Section 8.b., no amendment to this BA

Agreement shall be effective unless it is in writing and signed on behalf of Covered Entity and Business Associate.

c. Survival. The respective rights and obligations of Business Associate under Section 6.c. of this BA Agreement shall survive the termination of the Business Relationship and/or this BA Agreement. Sections 7 and 8 shall also survive the termination of the Business Relationship and/or this BA Agreement.

d. Regulatory and Statutory References. Any reference in this BA Agreement to a section of HIPAA, the Privacy Rule, the Security Rule, the HITECH Act, or any other regulations implementing HIPAA or the HITECH Act, shall mean such regulation or statute as in effect at the time of execution of this BA Agreement or, if and to the extent applicable, as subsequently updated, amended or revised.

e. Interpretation. Any conflict, inconsistency or ambiguity in or between this BA Agreement and HIPAA or the HITECH Act shall be resolved in favor of a meaning that permits Covered Entity to comply with HIPAA and the HITECH Act and any implementing regulations promulgated thereunder, including but not limited to the Privacy Rule and the Security Rule. Any conflict, inconsistency or ambiguity between this BA Agreement and any other contract between Business Associate and Covered Entity shall be resolved in favor of this BA Agreement.

f. No Third Party Beneficiary. Nothing in this BA Agreement is intended, nor shall be deemed, to confer any benefits on any third party.

g. Notices. Notwithstanding anything to the contrary in any document describing the Business Relationship, notices under this BA Agreement shall be sufficient only if in writing and personally delivered, delivered by a major commercial rapid delivery courier service, or mailed by certified or registered mail, postage prepaid and return receipt requested, to a party at the address set forth below or as amended by notice pursuant to this subsection.

If to Covered Entity:

Scott and White Health Plan
Attn: Privacy Officer, MS-AR-300
2401 S 31st St
Temple, TX 76508

with a copy to:

Scott and White Health Plan
Attn: Law Department, MS-20-D642
2401 S 31st St
Temple, TX 76508

If to Business Associate:

Attn: _____

h. Effect of BA Agreement. Except as amended by this BA Agreement, the terms and provisions of the Business Relationship shall remain in full force and effect.

i. Assignment. This BA Agreement may not be transferred or assigned by either party without the prior written consent of the other party, except that Covered Entity may assign this BA Agreement to a parent, subsidiary, or affiliate or to a successor by merger or consolidation without notice to or consent of Business Associate. Any assignment in violation of this provision is void and without effect. In the case of any permitted assignment or transfer of or under this BA Agreement, this BA Agreement or the relevant provisions shall be binding upon, and inure to the benefit of, the successors and permitted assigns of the parties hereto.

BUSINESS ASSOCIATE:

[BA]

By: _____
Title: _____
Date: _____

COVERED ENTITY:

SCOTT AND WHITE HEALTH PLAN

as agent for and on behalf of its affiliates which are covered entities

By: _____
Title: _____
Date: _____

**INDIVIDUAL PRODUCTS
AGENT AFFILIATION AGREEMENT**

This agreement is entered into by and between _____ (“Field Marketing Organization”) and _____ (“Agent”) and shall be effective as of the date of signature and shall remain in effect until terminated as provided herein.

In the event that this agreement is terminated, the FMO hereby agrees not to share, disclose, or make use of, and will treat as confidential, proprietary, protected, and take all reasonable precautions to prevent any unauthorized passing on, disclosure, or making any use of any confidential information of Agent.

This agreement may be canceled at any time by either party with 30 days written notice. The Agent then may affiliate with another FMO of the company (SWHP, ICSW will only allow one re-affiliation every 12 months). No amendment to this Agreement may occur without 30 days written notice.

This agreement shall not constitute an employee-employer relationship and Agent shall hold the FMO harmless for any negligent acts. Agent shall maintain their own Errors and Omissions coverage as required by SWHP and ICSW.

Compensation to the Agent will come directly from Scott and White Health Plan and/or Insurance Company of Scott and White.

This agreement includes *individual products* only provided by SWHP and/or ICSW.

No part of this agreement may supersede any of the laws of the State of Texas or the provisions set forth in FMO’s contracts with the carriers or Agent’s contracts with the carrier.

Signed this date _____, 2015, at _____, Texas.

FMO: _____

Agent: _____
(Signature) (Printed Name)

Tax ID # / SS# _____

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/disregarded entity name, if different from above	
	Check appropriate box for federal tax classification (required): <input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate	
	<input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶	
	<input type="checkbox"/> Other (see instructions) ▶	
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 the "Name" line 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.

Social security number									

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

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. citizen or other U.S. person (defined below).

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 U.S. person ▶	Date ▶
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General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

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.

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. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

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.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.



**SCOTT & WHITE
Healthcare**

ELECTRONIC FUNDS TRANSFER AUTHORIZATION AGREEMENT

VENDOR INFORMATION

New Request

Update

VENDOR NAME (COMPANY NAME)		VENDOR NUMBER (TO BE COMPLETED BY SCOTT & WHITE)	
ADDRESS	CITY	STATE	ZIP
ACCOUNTING/EFT CONTACT NAME	TELEPHONE NUMBER	FAX NUMBER	
IRS TAXPAYER ID (FEIN)	EMAIL ADDRESS FOR REMITTANCE ADVICE *	FAX NUMBER FOR REMITTANCE ADVICE *	
	(One email address only)		

(*Note: Select Email **OR** Fax for remittance method)

Above named Vendor hereby authorizes Scott & White Healthcare to originate Automated Clearing House electronic funds transfer (EFT) credit entries to Vendor's account, as indicated below, for payment of goods and/or services.

BANKING INFORMATION

BANK NAME	BANK ROUTING NUMBER	NAME ON ACCOUNT
CITY	STATE ZIP	BANK ACCOUNT NUMBER
BANK CONTACT NAME	TELEPHONE NUMBER	BANK ACCOUNT TYPE
		CHECKING ___ SAVINGS ___

Vendor acknowledges and agrees that the terms and conditions of all agreements with Scott & White Healthcare concerning the method and timing of payments for goods and services shall be amended as provided herein. Vendors whose previous payments were remitted via check will receive funds via ACH based on terms and conditions listed on individual invoices.

Vendors shall be responsible for any loss which may arise by reason of any error, mistake or fraud regarding the information Vendor has provided in this agreement.

Vendor may change any portion of the information provided under Bank Information by giving at least thirty (30) days written notice to Scott & White Healthcare to the mailing address shown below.

This authority shall remain in effect until fifteen (15) days after Financial Institution, at address shown above, and Scott & White Healthcare, at address shown below, have received written cancellation from Vendor. Notice of cancellation shall in no way affect credit or debit entries initiated prior to actual receipt and processing of notice. Vendor understands that Scott & White Healthcare may suspend this Agreement at any time.

By signing this Authorization, Vendor in no way relinquishes any legal right to dispute any item.

VENDOR AUTHORIZATION:

Authorized Name Authorized Signature Title Date