CENTRAL HEALTH PLAN OF CALIFORNIA

Broker Application

I. INSTRUCTIONS

This form should be typed or legibly printed in black or blue ink. If more space is needed than provided on original, attach additional sheets and reference the question being answered. Please do not use abbreviations when completing the application. **Current copies of the following documents must be submitted with this application:**

- ☐ Proof of State Insurance License
- ☐ Proof of Errors & Omissions Coverage
- ☐ W – 9 Form
- ☐ Broker Agreement
- ☐ Confidentiality Agreement
- ☐ First-Tier Attestation

II. BASIC INFORMATION

Last Name:	**First Name:**	**M.I.:**
Name of General Agency (if applicable):		

Mailing Address (*for payment – must match address on W9*):	City:	
	State:	ZIP:
Home Address:	City:	
	State:	ZIP:
Telephone Number: ( )	E-Mail:	
Fax Number: ( )	Cell Number: ( )	

III. PERSONAL INFORMATION

Service Area by County: ☐ Los Angeles ☐ San Bernardino ☐ Orange

Preferred Language: ☐ English ☐ Spanish ☐ Chinese ☐ Korean ☐ Vietnamese ☐ Other ______________________

Sex: ☐ Male ☐ Female	Date of Birth:
Social Security #:	Accident & Health License Number:

IV. ERRORS & OMISSIONS COVERAGE

Current Insurance Carrier:	Policy Number:	Original Effective Date:

Mailing Address:	City:	
	State:	ZIP:

Per Claim Amount: $	Aggregate Amount: $	Expiration Date:

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<u>Background - Please provide complete explanation of any "Yes" answers on a separate sheet:</u>

☐ Yes ☐ No 1. Have you ever plead guilty or been found guilty of a felony or crime, including but not limited to, crimes involving dishonesty, breach of trust, violation of any Federal law, or are you now under indictment?

☐ Yes ☐ No 2. Are you at present involved in any litigation or are there any unsatisfied judgments or liens (including State & Federal tax liens) against you?

☐ Yes ☐ No 3. Have you violated any Plan, Federal or State laws, rules and regulations in Marketing?

☐ Yes ☐ No 4. Do you owe an insurance company or other person for any premiums collected or monies advanced?

☐ Yes ☐ No 5. Have you ever had your insurance or securities license suspended or revoked by a State insurance regulatory agency (e.g., California Department of Insurance)?

☐ Yes ☐ No 6. Have you ever had a complaint filed against you with the California Department of Insurance, NASD or any other insurance regulatory agency or do you anticipate one being filed or have ever been terminated by any company for cause?

☐ Yes ☐ No 7. Has any company or other person alleged that it has not received premiums or other monies due such company or person from you?

☐ Yes ☐ No 8. Are you a first degree relative of a CMS provider? If yes, please specify the relationship (i.e. daughter, son or spouse): ____________________________

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BROKER
CONDITIONS AND AGREEMENTS

- I hereby affirm that I have reviewed this application and have answered all questions to the best of my knowledge.
- I hereby attest to all matters set forth above and agree to all matters set forth below.
- I hereby agree that if and when any or all of the companies issue to me any Agreement(s) for which I hereby apply, such Agreement(s) will bind me.
- I understand and agree that I have the opportunity to review such Agreement(s) and contract renewal term is contingent upon my annual completion of Marketing Training provided by Plan.
- I understand and agree that I have executed this Broker application as evidence of the understanding, acceptance and consent of its terms, and I agree that I will not solicit business until I received notification from the Company of acknowledgement and approval.
- I understand and agree that as an applicant, have the burden of producing adequate information for proper evaluation of professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.
- I understand that as part of its approval process, the Company may obtain an investigative consumer report which will confirm information regarding my character, general reputation, credit history, personal characteristics and mode of living, thus hereby authorize the Company to obtain such report.
- I understand that providers who receive payment from Medicare (i.e. Physicians, Pharmacists, Physical Therapists, and Provider Relatives, which include but are not limited to, spouses, sons, daughters, and others) are not qualified to enroll eligible Medicare beneficiaries into a Medicare plan.

I hereby affirm that the information submitted in this application and any addenda thereto is true, current, and correct, completed to the best of my knowledge and belief, and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my Agreement(s).

Print or Type Your Name Here: ____

Your Signature: ____

Today's Date: ____