

Call NAAIP Agent Services before filling out PDF.

Call Now: 1-800-770-0492



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Assurant Health Insurance Company Contracting Application

Highest Commissions – Guaranteed!

Highest commissions - Contracting - Assurant Health Insurance. Call NAAIP direct at **1-800-770-0492** for appointment. Alternatively, complete the attached application and sign where indicated. Fax or email your completed application along with copies of all insurance licenses for the states in which you will be soliciting business.

Please fax or email pages back to us that you have written on. Include your state insurance license(s) and void check. Void check must have pre-printed bank information - otherwise letter from the bank.

**Agents will be Contracted at the Highest Commission Level.
Call NAAIP Agent Services before filling out this PDF for a higher contract.**

1-800-770-0492

Available in AK, AL, AR, AZ, CA, DE, FL, GA, IA, ID, IL, IN, KS, KY, LA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NV, OH, OK, OR, PA, SC, SD, TN, TX, UT, VA, WA, WI, WV and WY.

Please go to <http://www.hellosign.com> to electronically fill out the contract. Hellosign is free.

Go to www.naaip.org to learn about our free agent websites with 3 quote engines and our free lead program. Monday thru Thursday conference call at Noon ET.

2014 Commission Schedule [Click Here](#)

For those contracted with another IMO [click here](#)

Sincerely,

Agent Services (www.naaip.org)

Tel: 1-800-770-0492

Fax: 1-866-436-1640

Email: [david \(at\) naaip.org](mailto:david@naaip.org)



AGENCY INFORMATION

1. Agency Name:

2. Assurant Agency Business No. / Tax ID No.:

3. RSD Name:

INDIVIDUAL AGENT INFORMATION

4. Agent's Name (Full legal name):

Nickname (Optional):

5. Social Security Number:

6. Date of Birth:

7. Resident Address: (Required)

STREET

CITY / STATE / ZIP (9 DIGIT)

PHONE

8. Business Address: (Optional)

STREET or P.O. BOX

CITY / STATE / ZIP (9 DIGIT)

PHONE

FAX

E-MAIL

9. License Requirements – We require a copy of your personal health and life license for your resident state and each non-resident state in which you intend to operate. Fees associated with these appointments will be charged to your General Agency's commission account where permitted. Please send copies of the appropriate licenses with this application.

10. Are you now or have you ever used any name other than shown above? Yes No If yes, list names, dates and reason used: _____

11. Have you ever been appointed with Time Insurance Company (previously known as Fortis Insurance Company?) Yes No If yes, list agent numbers: _____

12. Name of Errors and Omissions Carrier: (Optional) _____

Provide details to any "YES" answers for questions 13 – 15 on an attached sheet.

13. Have you ever had a professional license refused, revoked or suspended; or, has disciplinary action been taken against you by a regulatory agency? Yes No

14. Are you currently indebted to any insurance company or agency, or is there any dispute regarding your insurance accounts? Yes No

15. Have you ever pled guilty or no contest or been convicted of any violation of law other than minor traffic violations? Yes No

Products are underwritten and issued by:

Time Insurance Company

501 W Michigan
Milwaukee, WI 53201



16. List your residence address for past five years up to and including present date:

FROM (MO / YR)	TO (MO / YR)	ADDRESS	CITY / STATE / ZIP	PHONE

17. List all employers for past five years up to and including present date. Include dates, addresses, and positions:

FROM (MO / YR)	TO (MO / YR)	NAME / ADDRESS	CITY / STATE / ZIP	PHONE

IMPORTANT INFORMATION

Fair Credit Act -- I hereby authorize and request any present or former employer, police department, financial institution, insurance company, department of insurance or other persons having personal knowledge about me, to furnish bearer with any and all information in their possession regarding me in connection with an application for appointment as an insurance agent. I am willing that a photocopy of this authorization be accepted with the same authority as the original, and I specifically waive any written notice from any present or former employer who may provide information based upon this authorized request. I understand this authorization is to be part of the written agent application which I signed and applies to all companies, including any affiliated or import companies with which Assurant Health has a relationship, and products I may sell through that application.

Taxpayer Identification --Internal Revenue Code Section 6109 requires us to obtain your correct Federal Taxpayer Identification Number (TIN). This information is required so that payments can be accurately reported to you on Form 1099-MISC. Failure to provide us with correct information may subject your account to backup withholding. If this occurs, we must withhold and pay to the Internal Revenue Service 31% of certain payments made to your account.

Please Note:

This application cannot be processed unless all questions have been answered and appropriate license copies are attached. Fees associated with appointments will be charged to your commission account where permitted.

I represent that the answers given in this application are true and correct to the best of my knowledge and belief. I understand that any misrepresentations or misstatements may result in immediate cancellation of this appointment and the accompanying sales agreement. I grant full authorization to Time Insurance Company, Assurant Health and affiliated companies to communicate with me via fax, e-mail or any other electronic means at the numbers/address I have provided herein or at any number/address I subsequently provide to Time Insurance Company. I understand that such communications may qualify as advertisements under federal, state or local law and I consent to receive such advertisements. This authorization and permission shall remain effective until withdrawn by me in writing and received by Time Insurance Company.

AGENT'S SIGNATURE _____

DATE _____

GENERAL AGENT'S SIGNATURE (upline) _____

Company Use Only

RSD's SIGNATURE / HOME OFFICE AUTHORIZATION	Agent Business
Appointment Date	No.

Products are underwritten and issued by:

Time Insurance Company

501 W Michigan
Milwaukee, WI 53201



Time Insurance Company Producer Sales Agreement

This Producer Sales Agreement is between Time Insurance Company, by its current name or any new name or legal identity it may hold in the future, its subsidiaries and associated organizations (hereinafter referred to as the "Company" or "We" or "Us" or "Our") and

, "Producer" or "You" or "Your" or "Yours".

(Please print or type name)

The Producer agrees to comply with the following terms and conditions.



Producer

For Time Insurance Company

Signature

Signature

(Please print or type name)

Effective Date of Agreement
(To be completed by Home Office.)

Date

Producer #:

General Agent

GA Name (Please print)

GA Number

BENEFICIARY DESIGNATION:

Name

Present Address

if living, otherwise to:

Name

Present Address

DEFINITIONS

AGREEMENT. For the purposes of this Agreement, "Agreement" shall mean this Producer Sales Agreement, together with the Appointment Application, Commission and Product Schedules and any attachments, exhibits or schedules hereto.



Agent Commission Electronic Funds Transfer Form

Agent/Agency Name: _____

Agent/Agency Number: _____

Daytime Phone Number: _____
Area Code

Fax Number: _____
Area Code

Payment Frequency (Please check one): Weekly Semi-monthly Monthly

Statement Frequency (Please check one): Semi-monthly Monthly

Account Type (Please check one): Checking Account (22) Savings Account (32)

If you currently receive commission by electronic fund transfer, want to change frequencies and are not changing accounts, please check the following box:

Please make payments to my current depository.

If you are authorizing electronic fund transfer either for the first time or to a different account:

- 1. For checking account, please void a pre-printed blank check and attach here.
- 2. For savings account, please void a pre-printed deposit slip and attach here.

We cannot accept voided checks or deposit slips with a handwritten name & address

- 3. Please transfer the numbers at the bottom of the check or deposit slip into the fields below.

Your Bank's 9-Digit Routing Number
↓

and

Your Account Number
↓

Bank Routing Number

Account Number

Authorization

I hereby authorize Time Insurance Company to initiate credit entries and, if necessary, adjustments for any credit entries made in error to the checking or savings account indicated above, hereinafter called depository.



Agent Signature _____

Month Day Year

Please submit an updated authorization any time you change depositories.

For Time Insurance Company Use Only

Commission Vendor# _____ CC _____

Verified By _____ Date _____

Cash Management Keyed By _____ Verified By _____



Agent Name

SSN

General Agent's Name

GA Agent Number

List the states in which you are requesting appointment for this applicant.

Note: A legible copy of each state insurance license must be attached for each state. Fees associated with these appointments will be charged to the GA's commission account where permitted.

SELECT HOW AGENT IS TO BE PAID - Selection applies to ALL product lines.

Form section for selecting how the agent is to be paid, including options for General Agent pays Writing Agent, Company Pays Producer directly, and payment frequencies.

PRODUCT & COMPENSATION AUTHORIZATION - Select the products you are authorizing the Agent to sell by checking the appropriate box.

Form section for Individual Medical authorization, including schedule options and annualization choices.

Form section for Supplemental Coverage authorization, including schedule options and annualization choices.

Form section for Short Term Medical authorization, including schedule options.

A Writing Agent/Producer Appointment Application must be attached to process new agents/producers. I recommend appointing this agent per the above noted instructions.

General Agent's Signature (upline)

Date



Writing Agent Product Schedule							
<p>There are First Year and Second Year Plus options to choose from. You may combine them to suit your needs. For example, once you pick the appropriate First Year Rate (Option H, I or J), you can then combine it with Option L, K or J for the Second Year Plus. Subtract the Producer rates from your General Agent rate to calculate your override. Please note that Assurant Health Access, Suite Solutions and Integrated Dental cannot be assigned different levels. If you select H – H will be assigned for all three of these products</p>							
Assurant Health Accesssm							
Plan	Compensation Option	1st Year	Compensation Option	2nd	3rd – 4th	6+	
Assurant Health Access sm	J	20%	J	6%	5%	4%	
Assurant Health Access sm -MN & SD	J	10%	J	3%	2%	1%	
Assurant Health Access sm Issue Age 62+ All States	J	10%	J	10%	10%	0%	
Other Riders	Same as policy to which attached.						
Individual Medical							
Plan	First Year			Renewal			
Major Medical; Discount Card - All States but Washington	Compensation Option	Issue Age <62	Issue Age 62+	Compensation Option	Issue Age <62	2nd – 5th Issue Age 62+	6+ Issue Age 62+
	J	10%	6%	J	2%	6%	0%
Major Medical; Outpatient-Washington	J	8%		J	4%		
Dental/Vision Discount Card-Washington	J	40%		J	40%		
Major Medical Conversion	Pays 0% all years						
Other Riders	Same as policy to which attached.						
Health Advocates Alliance Suite Solutions – All States							
Plan	Compensation Option	First Year		Compensation Option	Renewal		
Suite Solutions uses the base plan duration when determining whether first year or renewal rates apply.	J	35%		J	13%		
Integrated Supplemental Products – All States – Unless Noted							
Accident	J	40%		J	6%		
Dental & Accident Medical Expense	J	35%		J	6%		
Critical Illness & Term Life	J	60%		J	8%		
Cancer & Heart Stroke	J	45%		J	6%		
Cancer & Heart/Stroke – CO, FL, MN & MI	J	40%		J	5%		

Products are underwritten and issued by:
Time Insurance Company
 501 W Michigan
 Milwaukee, WI 53201
 J-104980



Assurant Health Products – State Listing

Go to assuranthealthsales.com for all the materials and information you need to start selling today!

STATE	AK	AL	AR	AZ	CA	CO	CT	DC	DE	FL	GA	HI	IA	ID	IL	IN	KS	KY	LA	MA	MD	ME	MI	MN	MO	MS	MT	NC	ND	NE	NJ	NH	NM	NV	OH	OK	OR	PA	RI	SC	SD	TN	TX	UT	VA	WA	WI	WV	WY					
Assurant Health Access SM	✓	✓	✓	✓					✓	✓	✓		✓		✓	✓		✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓					✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓					
Individual Major Medical	★	★	★	★	★				★	★	★		★		★	★		★	★		★	★	★	★	★	★	★	★					★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★		
Short Term Medical	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Small Group Fully Insured	★	★	★	★	★			✓	✓	✓	✓		★		★	★		★	★		★	★	★	★	★	★	★	✓																										
Small Group Self-Funded												✓			✓				✓		✓	★	✓	✓	✓					★														✓							★			

Assurant Supplemental Coverage

	AK	AL	AR	AZ	CA	CO	CT	DC	DE	FL	GA	HI	IA	ID	IL	IN	KS	KY	LA	MA	MD	ME	MI	MN	MO	MS	MT	NC	ND	NE	NJ	NH	NM	NV	OH	OK	OR	PA	RI	SC	SD	TN	TX	UT	VA	WA	WI	WV	WY					
Accident Fixed Benefit	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Accident Medical Expense	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓		✓		✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Cancer and Heart/Stroke		✓											✓						✓				✓	✓	✓	✓	✓	✓						★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Term Life-Critical Illness	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dental	★	★	★	★	★	✓		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★

SuiteSolutions

	AK	AL	AR	AZ	CA	CO	CT	DC	DE	FL	GA	HI	IA	ID	IL	IN	KS	KY	LA	MA	MD	ME	MI	MN	MO	MS	MT	NC	ND	NE	NJ	NH	NM	NV	OH	OK	OR	PA	RI	SC	SD	TN	TX	UT	VA	WA	WI	WV	WY												
SecureSolution					✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓				
SelectSolution	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

* Available only for products underwritten by John Alden Life Insurance Company.

Additional products may be available in your state. Please check your state's product listing under Find a Form at: assuranthealthsales.com.

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★ new in state
 ★ Aetna Signature Administrators® network available

★ Issued through age 70; renewable up to 75