

DATA SHEET

united american insurance company

POST OFFICE BOX 8080, MCKINNEY, TX 75070

1 Print your FULL name: <input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mx.		SOCIAL SECURITY NUMBER	Please Attach Recent Glossy Photo Suitable For Fingerprint
Last First Middle			
2 Your BUSINESS address:		Your RESIDENCE address:	
Street Address		Street Address	
PO Box	City State	PO Box	City State
County	Zip	County	Zip
BUSINESS Phone # ()		RESIDENCE Phone # ()	
3 Check box if you prefer no publicity in our magazine. <input type="checkbox"/>			
4 Do you hold a current license for: <input type="checkbox"/> BROKER'S <input type="checkbox"/> LIFE & HEALTH <input type="checkbox"/> LIFE ONLY <input type="checkbox"/> HEALTH ONLY			
5 Date of Birth: / / Are you a citizen of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Place of Birth: _____			
Spouse's Name: _____			
Is your spouse licensed to sell Life or Accident & Health Insurance? _____			
6 Give the following information regarding all current and past appointments with life and/or health insurance companies:			
Name of Company	Address of Home Office	MO./YR.	MO./YR.
_____	_____	From _____ To _____	_____
_____	_____	From _____ To _____	_____
_____	_____	From _____ To _____	_____
_____	_____	From _____ To _____	_____
7 The following questions are asked because the answers are required by Insurance departments:			
Have you ever been convicted of a felony? _____ (If so, enclose particulars)			
Have you ever been refused or had suspended or revoked and insurance license in any state? _____ (If so, enclose particulars)			
Do you owe an unpaid balance to any insurance company? _____ (If so, enclose complete information)			
AUTHORIZATION TO OBTAIN INFORMATION			
I AUTHORIZE ANY CONSUMER REPORTING Agency, or any other organization, or person having knowledge of my character, reputation and financial position to give United American Insurance Company any and all such information. I understand that the information obtained by use of this authorization will be used by the Company to determine eligibility for agent appointments, and for other business purposes in connection with our relationship. I hereby release them from all liability for any damage that may ensue from furnishing this information.			
I understand that any information obtained will not be released by United American Insurance Company to any person or organization except to persons or organizations performing business or legal services in connection with this collection.			
I know that I may request to receive a copy of this authorization. I understand and agree that a photographic copy of this Authorization shall be valid as the original.			
I understand and agree that this Authorization shall be valid for two and one half years from date shown below.			
I also understand that I may request and receive a copy of this report.			
Date _____	<input checked="" type="checkbox"/> SIGNATURE OF AGENT APPLICANT	<input checked="" type="checkbox"/> SIGNATURE OF GENERAL AGENT	# AD4533 GA NUMBER

81088 SUB R-3 10/97

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("Agreement"), by and between United American Insurance Company ("United American" or "Covered Entity") and ("Underigned" or "Business Associate"), collectively the "Parties", is effective April 14, 2003 (the "Effective Date"). The purpose of this Agreement is to set forth the Parties' mutual agreement on the terms for their compliance with the Health and Insurance Portability and Accountability Act and its implementing regulations (45 C.F.R. Parts 160-164) ("HIPAA" or "Privacy Rule"). Capitalized terms used in this Agreement and not otherwise defined herein shall have the meanings set forth in HIPAA, which definitions are hereby incorporated by reference. The Parties acknowledge and agree that United American is a Covered Entity and that Underigned is a Business Associate with respect to United American, as these terms are defined by HIPAA. As set forth herein, Covered Entity intends: (1) Protected Health Information obtained by Business Associate to remain confidential in accordance with State and Federal law and sound business practices; and (2) Business Associate to use and disclose the Protected Health Information that it obtains from Covered Entity in a manner strictly adherent to State and Federal privacy laws, including, but not limited to, HIPAA. For purposes of this Agreement, "Protected Health Information" shall have the same meaning as the term "Protected Health Information" in 45 C.F.R. § 164.501, but limited solely to the protected health information created or received by Business Associate from or on behalf of Covered Entity.

Obligations and Activities of Business Associate

- a. Business Associate agrees not to use or disclose Protected Health Information other than as permitted or required by the Agreement or as Required By Law.
- b. Business Associate agrees to use appropriate physical, administrative and technical safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.
- c. Business Associate agrees 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 Agreement.
- d. Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement of which it becomes aware.
- e. Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity, agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.
- f. Where applicable, Business Associate agrees to provide access, at the request of 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.
- g. Where applicable, Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 C.F.R. § 164.526 at the request of Covered Entity or an individual.
- h. Business Associate agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity, available to Covered Entity, or to the Secretary or person or entity designated by the Secretary, for purposes of the Secretary's determining Covered Entity's compliance with the Privacy Rule.
- i. Business Associate agrees to document such instances 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.
- j. Business Associate agrees to provide to Covered Entity or an individual information collected in accordance with Section (i) of this 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.

Permitted Uses and Disclosures by Business Associate

Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information to perform its obligations, contractual or otherwise, to Covered Entity, provided that such use or disclosure, if done by Covered Entity, would not violate either the Privacy Rule or the minimum necessary policies and procedures of Covered Entity.

Obligations of Covered Entity

- a. Covered Entity shall notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 C.F.R. § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information.
- b. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by individual to use or disclose Protected Health Information, to the extent that such changes may affect Business Associate's use or disclosure of Protected Health Information.
- c. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.

Termination by Covered Entity

Covered Entity shall not require Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

Term and Termination

- a. **Term.** The Term of this Agreement shall commence on 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 information, in accordance with the termination provisions in this Section.
- b. **Termination for Cause.** Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:
 - a. Provide an opportunity for Business Associate to cure the breach or end the violation;
 - b. Immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and cure is not possible; or
 - c. If neither cure nor termination are feasible, Covered Entity shall report the violation to the Secretary.
- c. **Effect of Termination.**
 - a. Except as provided in paragraph (2) of this section, in the event of termination of this 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 provision 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 Protected Health Information.
 - b. In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon Covered Entity's acceptance that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this 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.

Miscellaneous

- a. **Regulatory References.** A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended.
- b. **Amendment.** The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of HIPAA and as the HIPAA privacy statutes and regulations may be amended from time to time.
- c. **Survival.** The respective rights and obligations of Business Associate set forth herein shall survive the termination of this Agreement.
- d. **Interpretation.** Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule.
- e. **Indemnity.** The Business Associate will indemnify and hold harmless Covered Entity and any of its affiliates, trustees, officers, directors, employees, volunteers or agents from and against any claim, cause of action, liability, damage, cost or expense, including attorneys' fees and court or proceeding costs, arising out of or in connection with any violation of, or failure of Covered Entity to fulfill its obligations under, HIPAA due to failure of Business Associate to fulfill its obligations under this Agreement. The Business Associate's obligation to indemnify Covered Entity will survive the expiration or termination of this Agreement. Covered Entity may, at its option, conduct the defense or settlement of any such action arising as described herein, and Business Associate shall fully cooperate with such defense.
- f. **No Third Party Beneficiaries.** This Agreement is entered into by and between the parties hereto for the exclusive benefit of each of the parties hereto, and may not be otherwise assigned by either party without the express written consent of the other. The Parties agree that there shall be no incidental or intended third-party beneficiaries under this Agreement. Nor shall any other person or entity have rights arising from the same.

IN WITNESS WHEREOF, the parties have affixed their hands and seals as of the Effective Date.

UNITED AMERICAN INSURANCE COMPANY

By: 
 Name: Mark S. McAndrew
 Title: CEO

By: Agent Signature X
 Printed Name: _____

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P. 06 15000094523 OCT 25 2004 16:57 P. 06

5020-699-7720 FAX: 912-999-3705

ENTRUST

WALTON, FLORIDA

OCT-17-2005 16:27

TOTAL P.07

(Must be read and signed by each sub-Agent applicant)

TO: UNITED AMERICAN INSURANCE COMPANY

I understand that United American Insurance Company does not compensate sub-Agents, that after I have become authorized to represent the Company, I may place business for the Company only through the General Agent (person or corporation) of the Company for whom I am designated as sub-Agent, that such General Agent alone will be accountable to me for my compensation in accordance with the contract or agreement that I have with such General Agent, and that the General Agent is not authorized to and cannot bind or obligate the company for my compensation or for the performance of any contract or agreement which such General agent may have with me.

I understand that United American Insurance Company prohibits solicitation of business by anyone who is not authorized to represent the Company by the insurance Department of the jurisdiction in which the solicitation takes place, and I agree that I will not solicit for the Company until my authority to represent the Company has been secure from the applicable insurance Department and is in my personal possession.

Witness:

[Signature]
(General Agent)

X
(Sub-Agent Applicant)

A04533
(General Agent Number)

Date

81336-RB 10/97

-HOME OFFICE USE ONLY-		
Contract #	Copy of License <input type="checkbox"/>	List Code _____
License Fee \$ _____	License # _____	Other _____
State License Form #	GA # _____	GA Name _____

Welcome to UAI Everyone in the Home Office looks forward to serving you.



POST OFFICE BOX 8080, MCKINNEY, TX 75070