



**A.D.K.**

**Appointment Data Kit**

Dear Valued Agent,

We appreciate your consideration in allowing INSMAX Insurance Brokerage Inc. to address your Life, Fixed Annuity, DI and LTC insurance appointment needs and are excited to have the privilege of offering you our services.

In order to complete your appointment request, please complete the following questionnaire. The questionnaire information will be processed through our software system, *SureLC*, a program which allows us to save and then retrieve your information from our database. In the future, should you desire to be appointed with an additional carrier, just let us know. Using *SureLC*, we will populate the carrier appointment kit with your information and signature along with the required documents, submit your appointment to the carrier in a timely fashion, and only contact you if there is need for additional information. The next time you hear from us about the appointment will be to let you know your carrier writing codes and effective dates.

In addition to completing the questionnaire, please complete and sign:

1. The Signature Authorization Page \*
2. The Credit Report Authorization Form \*
3. The Electronic Fund Transfer (EFT) Form \*

\*Signing and submitting the Signature Authorization Page and the Credit Report Authorization Form authorizes *SureLC* to submit your information through the software appointment program. Signing the EFT Authorization allows for carriers to direct deposit your commissions.

Your package also includes a Brokerage Advisor Agreement and Data Form. This is an Agreement between you and INSMAX Insurance Brokerage Inc. for services rendered. Please complete this Agreement in its entirety including signature and date.

Once you have completed all the forms and gathered all the documents listed on the "Required Documents" page, please fax to 610-239-6304 Attn: Candace Anders, L&C. You can also scan and email to [canders@INSMAX.com](mailto:canders@INSMAX.com).

Please contact Candace Anders at 877-446-7629 ext. 111 if you have any questions.

We look forward to working with you,

INSMAX Insurance Brokerage Inc.

Enclosures

# Demographic Package for Individual or Corporation/Entity Carrier Appointments

## 1 Appointment Type - Check only one:

**Individual:** (You are paid to your SSN. For EFT, you are paid to a Personal checking account which is under your SSN. You can provide proof of a resident producer insurance license, non-resident producer licenses for states in which you want to sell, E&O and personal void check for the EFT account. The required Certificate Proof of AML training (if not through LIMRA), LTC CE and/or Annuity training if required for the products you plan to sell is available and will be provided at the time of completing the form. If not, each will be provided upon request of INSMAX or the Carrier.)

or

**Corporation/Entity:** (You are paid to your Corporation/Entity Tax ID and for EFT, to the Corporation/Entity checking account which is under the Corporation/Entity Tax ID. In addition to the requirements under "Individual", you can provide the Corporation/Entity resident insurance license and, in place of the instructions for EFT for an Individual, the Corporation/Entity void check for the Corporation/Entity checking account.)

## 2 Individual Applicant Demographic Information – Check only one:

**Individual:** (Appointment is for you only – complete all Sections except Section 3)

or

**Officer/Principal of Corporation/Entity:** (Appointment is for both you and the Corporation/Entity – complete all Sections including Section 3)

First, Middle and Last Name (as it appears on your resident producer license):

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Social Security # \_\_\_\_\_ National Producer # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender Male \_\_\_\_\_ Female \_\_\_\_\_

City and State of Birth \_\_\_\_\_

Residential Address (not a P.O. Box) to include Street, Suite, City, State and Zip (as applies):

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County of \_\_\_\_\_

Residential Address Phone # \_\_\_\_\_

Email Address \_\_\_\_\_

Previous names used over last 7 years \_\_\_\_\_

Driver's License # \_\_\_\_\_ State of \_\_\_\_\_ Issue Date \_\_\_\_\_

Expiration Date \_\_\_\_\_

Business Address to include Street, Suite, City, State and Zip (as applies)

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County of \_\_\_\_\_

Business Phone # \_\_\_\_\_ Business Fax # \_\_\_\_\_

Business Email Address \_\_\_\_\_

**3. Incorporated Entity, Partnership or LLC Applicant Demographic Information – Check one:**

**Partnership**      **LLC**      **Incorporated Entity**      **Other** \_\_\_\_\_

Entity Name (as it appears on Resident Entity Insurance License):

\_\_\_\_\_

Tax ID Number \_\_\_\_\_

Entity Business Address include Street, Suite, City, State and Zip (as applies)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

County of \_\_\_\_\_

Entity Phone # \_\_\_\_\_ Entity Fax # \_\_\_\_\_

Email Address \_\_\_\_\_

Your Title as Principal of the Corporation/Entity \_\_\_\_\_

**4. Appointment States Requested**

Resident State of \_\_\_\_\_ Non-Resident States of \_\_\_\_\_

If requesting State of Florida, list counties for appointment \_\_\_\_\_

## 5. Legal Questions for Contracting and Appointment Requests

Please answer the following questions. If you answer "YES" to any question, be sure to provide a full detailed explanation including specific dates.

Name: \_\_\_\_\_

<b>1</b>	<b>Have you ever been charged or convicted of or plead guilty or no contest to any Felony, Misdemeanor, Federal/State insurance and/or securities or investments regulations or statutes? Have you ever been on probation?</b>	<input type="checkbox"/> <b>Yes</b>	<input type="checkbox"/> <b>No</b>
1A	Have you ever been convicted of or plead guilty or no contest to any Felony?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
1B	Have you ever been convicted of or plead guilty or no contest to any Misdemeanor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
1C	Have you ever been convicted of or plead guilty or no contest to a violation of federal or state securities or investment regulation or statutes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
1D	Have you ever been convicted of or plead guilty or no contest to a violation of state insurance department regulation or statutes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
1E	Has any foreign government, court, regulatory agency, or exchange ever entered an order against you related to investments or fraud?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
1F	Have you ever been charged with a Felony?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
1G	Have you ever been charged with a Misdemeanor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
1H	Have you ever been on probation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>2</b>	<b>Have you ever been or are you currently being investigated, have any pending indictment, lawsuits, or have you ever been in a lawsuit with an insurance company?</b>	<input type="checkbox"/> <b>Yes</b>	<input type="checkbox"/> <b>No</b>
2A	Are you currently under investigation by any legal or regulatory authority?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2B	Have you been under investigation by any insurance company?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2C	Have you ever been or are you currently involved in any pending indictments, lawsuits, civil judgements or other legal proceedings (civil or criminal)(you may omit family court)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2D	Have you ever been named as a defendant or codefendant in a lawsuit, or have you ever sued or been sued by an insurance company?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>3</b>	<b>Have you ever been alleged to have engaged in any fraud?</b>	<input type="checkbox"/> <b>Yes</b>	<input type="checkbox"/> <b>No</b>
<b>4</b>	<b>Have you ever been found to have engaged in any fraud?</b>	<input type="checkbox"/> <b>Yes</b>	<input type="checkbox"/> <b>No</b>
<b>5</b>	<b>Has any insurance or financial services company or broker-dealer terminated your contract or appointment or permitted you to resign for a reason other than lack of sales?</b>	<input type="checkbox"/> <b>Yes</b>	<input type="checkbox"/> <b>No</b>
5A	Were you fired because you were accused of violating insurance or investment related statutes, regulations, rules or industry standards of conduct?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5B	Were you fired because you were accused of fraud or the wrongful taking of property?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5C	Failure to supervise in connection with insurance or investment related statutes, regulations, rules or industry standards of conduct?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>6</b>	<b>Have you ever had an appointment with any insurance company denied or terminated for cause?</b>	<input type="checkbox"/> <b>Yes</b>	<input type="checkbox"/> <b>No</b>
<b>7</b>	<b>Does any insurer, insured, or other person claim any commission chargeback or other indebtedness from you as a result of any insurance transactions or business?</b>	<input type="checkbox"/> <b>Yes</b>	<input type="checkbox"/> <b>No</b>

8	<b>Has any lawsuit or claim ever been made against you, your surety company, or errors and omissions insurer arising out of your sales or practices, or have you been refused surety bonding or E&amp;O coverage?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
8A	Has a bonding or surety company ever denied, paid on or revoked a bond for you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8B	Has an Errors & Omissions (E&O) carrier ever denied, paid claims on or cancelled your coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9	<b>Have you ever had an insurance or securities license denied, suspended, cancelled or revoked?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
10	<b>Has any state or federal regulatory body found you to have been a cause of an investment - or insurance - related business having its authorization to do business denied, suspended, revoked, or restricted?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
11	<b>Has any state or federal regulatory agency revoked or suspended your license as an attorney, accountant, or federal contractor?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
12	<b>Has any state or federal regulatory agency found you to have made a false statement or omission or been dishonest, unfair, or unethical?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
13	<b>Have you had any interruptions in licensing?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
14	<b>Has any state, federal or self-regulatory agency filed a complaint against you, fined, sanctioned, censured, penalized or otherwise disciplined you for a violation of their regulations or state federal statutes? Have you ever been the subject of a consumer initiated complaint?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
14A	Has any regulatory body ever sanctioned, censured, penalized or otherwise disciplined you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14B	Has any state, federal, or self-regulatory, agency files a complaint against you, fined or sanctioned you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14C	Have you ever been the subject of a consumer initiated complaint?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15	<b>Have you personally or any insurance or securities brokerage firm with whom you have been associated filed a bankruptcy petition or declared bankruptcy?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
15A	Have you personally filed a bankruptcy petition or declared bankruptcy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15B	Has any insurance or securities brokerage firm with whom you have been associated filed a bankruptcy petition or been declared bankrupt either during your association or within 5 years after termination of such association?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15C	Is a bankruptcy pending?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16	<b>Are there any unsatisfied judgements, garnishments or liens against you?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
17	<b>Are you connected in any way with a bank, savings &amp; loan association, or other lending or financial institution?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
18	<b>Have you ever used any other names or aliases?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
19	<b>Do you have any unresolved matters pending with the Internal Revenue Service or other taxing authority?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered any question "YES", provide an explanation that includes dates, actions, and descriptions. Attach additional paper if necessary.

I attest that the information I have provided is true to the best of my knowledge. I acknowledge that if any information changes, I will notify INSMAX within 5 days of such change. Further, I understand that INSMAX may contact me when I need to answer carrier specific questions.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**6. Details to All Legal Questions Answered as "YES". List question number then answer. If All Legal Questions Answered "No", skip this section. (Duplicate page as often as necessary for answers)**

Question # \_\_\_\_\_

Date of Action \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Your Action and Response to Your Action: \_\_\_\_\_

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Resolution (include copies of dollar amounts, payments schedules, void checks, letters, Court documents as appropriate, etc)

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**7. Additional Licenses/Certificates: Circle as many as apply and list last date of testing:**

**AML LIMRA** Test Date \_\_\_\_\_ Other Vendor Test Date \_\_\_\_\_ and  
Provider Certificate

**LTC CE** Test Date \_\_\_\_\_ and Provider Certificate

**Annuity** Test Date \_\_\_\_\_ and Provider Certificate

**FINRA** Are you a registered Rep? Yes No  
If Yes, Broker/Dealer Name \_\_\_\_\_ Your CRD# \_\_\_\_\_

**8. Employment History – Please provide for last 5 years include Street, Suite, City, State and Zip (as applies)**

From \_\_\_/\_\_\_/\_\_\_\_\_ to \_\_\_/\_\_\_/\_\_\_\_\_

Company \_\_\_\_\_

Position \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

From \_\_\_/\_\_\_/\_\_\_\_\_ to \_\_\_/\_\_\_/\_\_\_\_\_

Company \_\_\_\_\_

Position \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

From \_\_\_/\_\_\_/\_\_\_\_\_ to \_\_\_/\_\_\_/\_\_\_\_\_

Company\_\_\_\_\_

Position\_\_\_\_\_

Address\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

From \_\_\_/\_\_\_/\_\_\_\_\_ to \_\_\_/\_\_\_/\_\_\_\_\_

Company\_\_\_\_\_

Position\_\_\_\_\_

Address\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

From \_\_\_/\_\_\_/\_\_\_\_\_ to \_\_\_/\_\_\_/\_\_\_\_\_

Company\_\_\_\_\_

Position\_\_\_\_\_

Address\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**9. Residential Address History – Please provide for last 5 years include Street, Suite, City, State and ZIP (as applies)**

From \_\_\_/\_\_\_/\_\_\_\_\_ to \_\_\_/\_\_\_/\_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

From \_\_\_/\_\_\_/\_\_\_\_\_ to \_\_\_/\_\_\_/\_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

From \_\_\_/\_\_\_/\_\_\_\_\_ to \_\_\_/\_\_\_/\_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

From \_\_\_/\_\_\_/\_\_\_\_\_ to \_\_\_/\_\_\_/\_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Signature Authorization**

PLEASE READ THIS AUTHORIZATION, SIGN IN THE BOX BELOW AND SUBMIT THIS FORM BY FOLLOWING THE INSTRUCTIONS PROVIDED ON THE COVER PAGE.

I, \_\_\_\_\_, hereby authorize SuranceBay, LLC and its general agency customers (the “Authorized Parties”) to affix or append a copy of my signature, as set forth below, to any and all required signature fields on forms and agreements of any insurance carrier (a “Carrier”) designated by me through the SureLC software or through any other means, including without limitation, by e-mail or orally. The Authorized Parties shall be permitted to complete and submit all such forms and agreements on my behalf for the purpose of becoming authorized to sell Carrier insurance products. I hereby release, indemnify and hold harmless the Authorized Parties against any and all claims, demands, losses, damages, and causes of action, including expenses, costs and reasonable attorney’s fees which they may sustain or incur as a result of carrying out the authority granted hereunder.

By my signature below, I certify that the information I have submitted to the Authorized Parties is correct to the best of my knowledge and acknowledge that I have read and reviewed the forms and agreements which the Authorized Parties have been authorized to affix my signature. I agree to indemnify and hold any third party harmless from and against any and all claims, demands, losses, damages, and causes of action, including expenses, costs and reasonable attorney’s fees which such third party may incur as a result of its reliance on any form or agreement bearing my signature pursuant to this authorization.

Please sign in the center of the box below. Please use BLACK ink



PRODUCERIDXXX

**Credit Report Authorization Form**

I hereby authorize SuranceBay, LLC, and its customers, which may include insurance providers and general agencies, (collectively, the "Authorized Parties") to review and/or verify any information provided by me or any third party pertaining to me, and to obtain and/or review additional information from any source, including through a consumer report and/or investigative consumer report, whereby information is obtained through credit reporting agencies, previous employers, and regulatory, state and local law enforcement databases and others, for purposes of establishing my eligibility for appointment and retention as an agent or representative of the Authorized Parties.

I further agree that this authorization to obtain a consumer report and other information about me shall be ongoing for any other legitimate purpose consistent with this Authorization Form as determined by the Authorized Parties.

In the event the undersigned resides in a state with legal requirement to provide a free copy of certain consumer reports, SuranceBay, LLC will instruct the applicable consumer reporting agency to send a copy of any such reports obtained hereunder to the address provided below.

The undersigned further waives any right or claim which the undersigned would otherwise have under the Fair Credit Reporting Act in the absence of this continuing consent. A copy of this authorization is as valid as the original.

Acknowledged and agreed to this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, by:

X \_\_\_\_\_  
Signature

Name:  
\_\_\_\_\_

Address:  
\_\_\_\_\_

Social Security Number:  
\_\_\_\_\_

**ELECTRONIC FUND TRANSFERS (EFT)**

Name on Account (Required): \_\_\_\_\_

SS# or Tax ID: \_\_\_\_\_

Routing/Transit/ABA #: \_\_\_\_\_

Account #: \_\_\_\_\_

Financial Institution Name: \_\_\_\_\_

Branch Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Account Type:  Checking  Savings Phone: \_\_\_\_\_

By signing below, I hereby authorize the Company to initiate credit entries and, if necessary, adjustments for credit entries in error to the checking and/or savings account indicated on this form. This authority is to remain in full effect until the Company has received written notification from me of its termination. I understand that this authorization is subject to the terms of any agent or representative contract, commission agreement, or loan agreement that I may have now, or in the future, with the Company.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Attach copy of the check here for checking account  
or deposit slip for savings account.**

**No starter checks or deposit slips allowed for  
checking accounts.**

# Required Documents

Please return this page with the copies of the following required documents:

- 1. Resident Producer Insurance License** (need for both Individual and Corporation/Entity Appointments)
- 2. Non-Resident Producer Insurance License(s)** if selling in Non-Resident states (needed for both Individual and Corporation/Entity Appointments)
- 3. Resident Entity Insurance License** (needed for Corporation/Entity Appointments Only)
- 4. Non-Resident Entity Insurance License(s)** if selling in Non-Resident states (needed for Corporation/Entity Appointments Only)
- 5. Certificate Proof of AML Training** if not taken through LIMRA
- 6. Certificate Proof of LTC CE and/or Annuity Training** if required by carrier for the type of product being sold
- 7. Declaration Page of E&O** showing Policy Number, Effective Date, Expiration Date, and Full Name of agent covered. If the individual's name is not listed on the declaration page, in addition, please include a **letter on company letterhead** dated and signed by an officer of the Corporation/Entity stating the individual is covered under the E&O policy.
- 8. The appropriate void check/deposit slip** to match the completed EFT form  
Personal account checks/deposit slips for Individual Appointments and  
Corporation/Entity account checks/deposit slips for Corporation/Entity Appointments
- 9. Signed INSMAX Independent Producer Agreement**





- 3) THE PRODUCER AGREES THAT INSMAX HAS A RIGHT OF OFFSET AGAINST ALL COMMISSIONS AND ANY OTHER COMPENSATION PAYABLE BY INSMAX TO PRODUCER UNDER THIS AGREEMENT OR UNDER ANY OTHER EXISTING OR FUTURE AGREEMENT WITH INSMAX, AS SECURITY FOR THE PAYMENT OF ANY EXISTING OR FUTURE DEBIT BALANCE OR OTHER INDEBTEDNESS OF PRODUCER TO INSMAX. INSMAX MAY AT ANY TIME AND FROM TIME TO TIME, WITH OR WITHOUT NOTICE OR JUDICIAL ACTION, EXERCISE SUCH RIGHT BY OFFSETTING SUCH INDEBTEDNESS AGAINST ANY COMMISSIONS AND OTHER COMPENSATION OTHERWISE DUE TO PRODUCER. THIS RIGHT OF OFFSET SHALL NOT BE EXTINGUISHED BY THE TERMINATION OF THIS AGREEMENT OR ANY OTHER AGREEMENT. THE PRODUCER SHALL IMMEDIATELY REPAY TO INSMAX ALL COMPENSATION RECEIVED FROM POLICIES IN WHICH PREMIUMS HAVE BEEN RETURNED OR IN WHICH THE POLICY HAS BEEN SUBJECT TO RECAPTURE OR IN WHICH INSMAX IS OTHERWISE CHARGED BACK OR IN WHICH THE PRODUCER HAS BEEN OVERPAID. THE PRODUCER AGREES THAT ANY REASONABLE ATTORNEYS' FEES ASSOCIATED WITH THE COLLECTION OF SUCH COMPENSATION SHALL BE THE RESPONSIBILITY OF AND SHALL BE REIMBURSED BY THE PRODUCER TO INSMAX.
  
- 4) THE PRODUCER CERTIFIES THAT HE OR SHE HAS NEVER BEEN CONVICTED OF A FEDERAL OR STATE FELONY INVOLVING DISHONESTY OR BREACH OF TRUST; OR IF SO, THAT PRODUCER HAS RECEIVED WRITTEN AUTHORIZATION FROM THE APPLICABLE STATE INSURANCE COMMISSIONER SPECIFICALLY REFERENCING SECTION 1033 OF THE VIOLENT CRIME CONTROL AND LAW ENFORCEMENT ACT OF 1994, SUBSECTION (3)(2) GRANTING PERMISSION TO WORK IN THE INSURANCE INDUSTRY.
  
- 5) THE PRODUCER WILL USE HIS/HER BEST EFFORTS TO PLACE THE SALE OF INSURANCE PRODUCTS THROUGH INSMAX WITH INSMAX CARRIERS, WHEN INSMAX HAS PROVIDED MARKETING SUPPORT, ADVANCED SALES, NEW BUSINESS OR UNDERWRITING SUPPORT ON THE SALE.
  
- 6) EACH PARTY TO THIS AGREEMENT SHALL INDEMNIFY AND HOLD HARMLESS THE OTHER PARTY AGAINST ANY AND ALL CLAIMS, ACTIONS, DAMAGES, LOSSES AND LIABILITIES (INCLUDING, WITHOUT LIMITATION, REASONABLE ATTORNEYS' FEES) (COLLECTIVELY "LOSSES") ARISING FROM (A) ANY WRONGFUL, UNLAWFUL, OR TORTIOUS ACT OR OMISSION, OR ALLEGEDLY WRONGFUL, UNLAWFUL OR TORTIOUS ACT OR OMISSION, OR (B) ANY FAILURE TO COMPLY WITH ANY OBLIGATION UNDER THIS AGREEMENT, IN EACH CASE ON THE PART OF THE INDEMNIFYING PARTY OR ANY OF THE INDEMNIFYING PARTY'S AGENTS OR EMPLOYEES. NOTWITHSTANDING THE FOREGOING, NEITHER PARTY SHALL BE OBLIGATED TO INDEMNIFY THE OTHER PARTY FOR THE AMOUNTS OF ANY LOSSES WHICH HAVE ACTUALLY BEEN REIMBURSED PURSUANT TO ERRORS AND OMISSIONS LIABILITY INSURANCE MAINTAINED BY THE OTHER PARTY.
  
- 7) THE PRODUCER SHALL AT ALL TIMES COMPLY WITH ALL APPLICABLE INSURANCE REGULATIONS AND ALL OTHER APPLICABLE STATE AND FEDERAL LAWS AND REGULATIONS. THIS INCLUDES, BUT IS NOT LIMITED TO:
  - A) TITLE V OF THE GRAMM-LEACH-BLILEY ACT ("GLB") (15 U.S.c. 6801, ET SEQ.);
  - B) THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPAA"), INCLUDING ITS IMPLEMENTING PRIVACY REGULATIONS AT 45 C.F.R. PARTS 160 - 164 AND ITS IMPLEMENTING SECURITY REGULATIONS AT 45 C.F.R. PARTS 160, 162, AND 164;
  - C) THE USA PATRIOT ACT OF 2001 (PUB.L NO. 107-56), INCLUDING, WITHOUT LIMITATION, THE REQUIREMENT TO DEVELOP AND IMPLEMENT "ANTI-MONEY LAUNDERING" PROGRAMS AND "CUSTOMER IDENTIFICATION PROGRAMS";
  - D) APPLICABLE STATE AND FEDERAL "DO NOT CALL" LAWS AND REGULATIONS, INCLUDING, BUT NOT LIMITED TO, THE NATIONAL "DO NOT CALL" REGISTRY RULES UNDER THE TELEPHONE CONSUMER PROTECTION ACT OF 1991 ("TCPA") (47 U.S.c. 227, ET SEQ);
  - E) THE RESTRICTIONS ON SENDING COMMERCIAL FAXES FOUND IN THE TCPA AND THE REGULATIONS ENACTED UNDER THE TCPA; AND
  - F) THE VARIOUS STATE AND FEDERAL RESTRICTIONS ON THE USE OF ELECTRONIC MAIL AND THE CONTROLLING THE ASSAULT OF NON-SOLICITED PORNOGRAPHY AND MARKETING ACT OF 2003 (15 U.s.c. § 7708) ("CAN-SPAM ACT").
  
- 8) EACH PARTY WILL NOT USE OR DISCLOSE NONPUBLIC PERSONAL INFORMATION, I.E., PERSONALLY IDENTIFIABLE INFORMATION, INCLUDING BUT NOT LIMITED TO FINANCIAL OR HEALTH INFORMATION, THAT IS NOT PUBLICLY AVAILABLE ("PROTECTED INFORMATION"), ABOUT INDIVIDUALS WHO SEEK TO OBTAIN OR OBTAIN INSURANCE PRODUCTS AND/OR SERVICES THROUGH THE PRODUCER ("CONSUMERS") OR WHO HAVE A CONTINUING RELATIONSHIP WHEREIN THE INDIVIDUALS HAVE ONE OR MORE INSURANCE PRODUCTS AND/OR SERVICES THROUGH PRODUCER ("CUSTOMERS"), EXCEPT AS PROVIDED HEREIN.

EACH PARTY WILL TREAT PROTECTED INFORMATION AS CONFIDENTIAL AND ACCESS TO PROTECTED INFORMATION WILL BE LIMITED TO THOSE OFFICERS, EMPLOYEES, AGENTS OR REPRESENTATIVES OF EACH PARTY WHO NEED

TO USE THE INFORMATION IN CONNECTION WITH UNDERWRITING, CLAIMS ADMINISTRATION OR OTHER SERVICING OF INSURANCE PRODUCTS AND/OR SERVICES FOR A PARTICULAR CONSUMER OR CUSTOMER.

EACH PARTY WILL NOT USE OR DISCLOSE, OR PERMIT ANY OF ITS OFFICERS, EMPLOYEES, AGENTS OR REPRESENTATIVES TO USE OR DISCLOSE PROTECTED INFORMATION EXCEPT: (I) AS NECESSARY TO MEET THE PURPOSE OF THIS AGREEMENT; (II) AS AUTHORIZED BY THE CONSUMER OR CUSTOMER; (III) AS IN COMPLIANCE WITH EACH PARTY'S THEN CURRENT PRIVACY POLICY; (IV) AS REQUIRED BY LAW; OR (V) AS OTHERWISE PERMITTED IN ACCORDANCE WITH APPLICABLE FEDERAL AND STATE LAWS AND REGULATIONS, INCLUDING, GLB AND HIPAA, AND THE REGULATIONS PROMULGATED THEREUNDER.

EACH PARTY WILL ESTABLISH APPROPRIATE STANDARDS FOR SAFEGUARDING PROTECTED INFORMATION WITHIN ITS CONTROL, I.E., THE PRODUCER WILL ESTABLISH HIS/HER OWN INTERNAL SECURITY GUIDELINES.

- 9) PRODUCER TO TAKE SUCH STEPS AS SHALL BE NECESSARY TO ENSURE THAT (I) THE INFORMATION SUBMITTED TO INSMAX BY PRODUCER (INCLUDING ANY INFORMATION CONTAINED IN ANY APPLICATION FOR ANY POLICY) IS, TO THE BEST OF PRODUCER'S KNOWLEDGE (AFTER REASONABLE INQUIRY), ACCURATE AND COMPLETE AND (II) ANY AND ALL MEDICAL INFORMATION CONCERNING AN INSURED THAT IS SUBMITTED TO INSMAX IN CONNECTION WITH A PROPOSED TRANSACTION (INCLUDING, WITHOUT LIMITATION, ANY MEDICAL RECORDS, EXAMS, LABORATORY REPORTS AND INSPECTION REPORTS) ARE THE SAME SET OF INFORMATION THAT WAS SUBMITTED TO ANY LIFE INSURANCE CARRIER IN CONNECTION WITH A PROPOSED ISSUANCE OF A POLICY OR ANY ANNUITY COMPANY IN CONNECTION WITH A PROPOSED ISSUANCE OF AN ANNUITY.
- 10) PRODUCER AGREES THAT INSMAX WILL HAVE NO OTHER INVOLVEMENT IN THE PRODUCT SALES OTHER THAN PERFORMING THE ROLE AS GENERAL AGENCY FOR THE INSMAX CARRIERS. BY PERFORMING THIS LIMITED ROLE, INSMAX DOES NOT MAKE, AND SPECIFICALLY DISCLAIMS ANY ENDORSEMENT OR APPROVAL OF ANY MARKETING OR SALES CONCEPT, NOR DOES INSMAX MAKE ANY REPRESENTATIONS TO PRODUCER OR ANY THIRD PARTY REGARDING TAX, LEGAL OR OTHER ECONOMIC CONSEQUENCES RAISED BY ANY MARKETING OR SALES CONCEPT. THE PARTIES AGREE THAT INSMAX SHALL NOT ACT AS NOR BE CONSIDERED A PROMOTER OF ANY MARKETING OR SALES CONCEPT. PRODUCER SHALL NOT CONSTRUE ANY STATEMENTS MADE OR ACTIONS TAKEN BY INSMAX OR ITS EMPLOYEES OR AGENTS AS TAX, LEGAL OR OTHER ADVICE REGARDING ANY MARKETING OR SALES CONCEPT, AND SHALL NOT REPRESENT TO ANY CLIENT OR OTHER THIRD PARTY THAT INSMAX OR ITS EMPLOYEES OR AGENTS HAVE GIVEN ANY SUCH ADVICE.
- 11) NEITHER THE TERMINATION NOR EXPIRATION OF THIS AGREEMENT FOR ANY REASON SHALL RELEASE OR OPERATE TO DISCHARGE ANY PARTY FROM ANY LIABILITY OR OBLIGATION THAT MAY HAVE ACCRUED PRIOR TO SUCH TERMINATION OR EXPIRATION. IN ADDITION, THE PROVISIONS OF SECTIONS 3, 6, 8, 11, 12 AND 13 OF THIS AGREEMENT SHALL SURVIVE THE EXPIRATION OR TERMINATION, FOR ANY REASON, OF THIS AGREEMENT, EXCEPT FOR REASONS IN WHICH LIABILITIES FOR EITHER PARTY NO LONGER EXIST.
- 12) PREVENTION OF FRAUD. PRODUCER ACKNOWLEDGES AND AGREES THAT IT HAS AN AFFIRMATIVE OBLIGATION TO PREVENT FRAUD BY CLIENTS AND PRODUCER, AND PRODUCER SHALL NOT TAKE ANY ACTION OR FAIL TO TAKE ANY ACTION, DIRECTLY OR INDIRECTLY, THAT COULD MISLEAD OR DEFRAUD AN INSURANCE COMPANY OR FINANCIAL INSTITUTION IN CONNECTION WITH THE ISSUANCE OF ANY POLICY OR ANNUITY (OR THE FINANCING THEREOF) AND SHALL USE ITS BEST EFFORTS TO PREVENT ANY SUCH FRAUD BY OTHERS. IN CONNECTION WITH THE SUBMISSION OF ANY APPLICATION, PRODUCER HEREBY REPRESENTS AND WARRANTS TO INSMAX THAT AS OF THE DATE OF SUCH SUBMISSION, TO THE BEST OF ITS KNOWLEDGE AFTER REASONABLE INQUIRY, THE INFORMATION IN ANY APPLICATION, AND ANY OTHER INFORMATION PROVIDED BY AN INSURED, OWNER OR PRODUCER TO INSMAX IN CONNECTION WITH SUCH APPLICATION, IS ACCURATE, COMPLETE, CORRECT AND NOT MISLEADING AND THAT THE INFORMATION IN THE APPLICATION NOT MISLEADING. IF AT ANY TIME PRODUCER BECOMES AWARE OF ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION CONTAINED IN ANY APPLICATION OR WOULD MAKE ANY INFORMATION CONTAINED IN THE APPLICATION MISLEADING, PRODUCER WILL IMMEDIATELY PROVIDE WRITTEN NOTICE TO INSMAX. ANY BREACH BY PRODUCER OF THIS SECTION SHALL RESULT IN IMMEDIATE TERMINATION OF PRODUCER'S RELATIONSHIP WITH INSMAX.

PRODUCER UNDERSTANDS THAT IN THE EVENT INSMAX HAS ANY REASON TO BELIEVE THAT ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION HAS BEEN PROVIDED TO IT OR TO ANY INSURANCE COMPANY OR FINANCIAL INSTITUTION OR THAT PRODUCER OR ANY CLIENTS INTRODUCED TO INSMAX BY PRODUCER HAS TAKEN ANY ACTION FOR THE PURPOSE OF DEFRAUDING ANY INSURANCE COMPANY OR FINANCIAL INSTITUTION, INSMAX WILL IMMEDIATELY (AND WITHOUT PROVIDING ANY PRIOR NOTICE TO PRODUCER) REPORT SUCH CONDUCT TO, AND ASSIST WITH ANY INVESTIGATION BY, THE RELEVANT STATE INSURANCE COMMISSIONER, SUCH COMPANY OR FINANCIAL INSTITUTION AND/OR ANY OTHER REGULATOR.

- 13) BY THE DISCLOSURE OF BASIC CONTACT INFORMATION ABOVE, SUCH INFORMATION INCLUDING ADDRESS, PHONE NUMBER, FAX NUMBER AND E-MAIL ADDRESS (THE "CONTACT INFORMATION"), THE PRODUCER HEREBY CONSENTS TO ALLOW INSMAX TO USE SUCH CONTACT INFORMATION FOR MARKETING PURPOSES.
- 14) COMPLIANCE WITH HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) – BUSINESS ASSOCIATE PROVISIONS

A) DEFINITIONS

- I. CATCH-ALL DEFINITIONS: THE FOLLOWING TERMS USED IN THIS AGREEMENT SHALL HAVE THE SAME MEANING AS THOSE TERMS IN THE HIPAA RULES: BREACH, DATA AGGREGATION, DESIGNATED RECORD SET, DISCLOSURE, HEALTH CARE OPERATIONS, INDIVIDUAL, MINIMUM NECESSARY, NOTICE OF PRIVACY PRACTICES, PROTECTED HEALTH INFORMATION, REQUIRED BY LAW, SECRETARY, SECURITY INCIDENT, SUBCONTRACTOR, UNSECURED PROTECTED HEALTH INFORMATION, AND USE.
- II. SPECIFIC DEFINITIONS:
  - A. BUSINESS ASSOCIATE. "BUSINESS ASSOCIATE" SHALL GENERALLY HAVE THE SAME MEANING AS THE TERM "BUSINESS ASSOCIATE" AT 45 CFR 160.103, AND IN REFERENCE TO THE PARTY TO THIS AGREEMENT, SHALL MEAN PRODUCER.
  - B. COVERED ENTITY. "COVERED ENTITY" SHALL GENERALLY HAVE THE SAME MEANING AS THE TERM "COVERED ENTITY" AT 45 CFR 160.103, AND IN REFERENCE TO THE PARTY TO THIS AGREEMENT, SHALL MEAN INSMAX.
  - C. HIPAA RULES. "HIPAA RULES" SHALL MEAN THE PRIVACY, SECURITY, BREACH NOTIFICATION, AND ENFORCEMENT RULES AT 45 CFR PART 160 AND PART 164.

B) OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE

- I. BUSINESS ASSOCIATE AGREES TO:
  - A. NOT USE OR DISCLOSE PROTECTED HEALTH INFORMATION OTHER THAN AS PERMITTED OR REQUIRED BY THE AGREEMENT OR AS REQUIRED BY LAW;
  - B. USE APPROPRIATE SAFEGUARDS, AND COMPLY WITH SUBPART C OF 45 CFR PART 164 WITH RESPECT TO ELECTRONIC PROTECTED HEALTH INFORMATION, TO PREVENT USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION OTHER THAN AS PROVIDED FOR BY THE AGREEMENT;
  - C. REPORT TO COVERED ENTITY ANY USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION NOT PROVIDED FOR BY THE AGREEMENT OF WHICH IT BECOMES AWARE, INCLUDING BREACHES OF UNSECURED PROTECTED HEALTH INFORMATION AS REQUIRED AT 45 CFR 164.410, AND ANY SECURITY INCIDENT OF WHICH IT BECOMES AWARE;
  - D. IN ACCORDANCE WITH 45 CFR 164.502(E)(1)(II) AND 164.308(B)(2), IF APPLICABLE, ENSURE THAT ANY SUBCONTRACTORS THAT CREATE, RECEIVE, MAINTAIN, OR TRANSMIT PROTECTED HEALTH INFORMATION ON BEHALF OF THE BUSINESS ASSOCIATE AGREE TO THE SAME RESTRICTIONS, CONDITIONS, AND REQUIREMENTS THAT APPLY TO THE BUSINESS ASSOCIATE WITH RESPECT TO SUCH INFORMATION;
  - E. MAKE AVAILABLE PROTECTED HEALTH INFORMATION IN A DESIGNATED RECORD SET TO THE COVERED ENTITY AS NECESSARY TO SATISFY COVERED ENTITY'S OBLIGATIONS UNDER 45 CFR 164.524;
  - F. MAKE ANY AMENDMENT(S) TO PROTECTED HEALTH INFORMATION IN A DESIGNATED RECORD SET AS DIRECTED OR AGREED TO BY THE COVERED ENTITY PURSUANT TO 45 CFR 164.526, OR TAKE OTHER MEASURES AS NECESSARY TO SATISFY COVERED ENTITY'S OBLIGATIONS UNDER 45 CFR 164.526;
  - G. MAINTAIN AND MAKE AVAILABLE THE INFORMATION REQUIRED TO PROVIDE AN ACCOUNTING OF DISCLOSURES TO THE COVERED ENTITY AS NECESSARY TO SATISFY COVERED ENTITY'S OBLIGATIONS UNDER 45 CFR 164.528;
  - H. TO THE EXTENT THE BUSINESS ASSOCIATE IS TO CARRY OUT ONE OR MORE OF COVERED ENTITY'S OBLIGATION(S) UNDER SUBPART E OF 45 CFR PART 164, COMPLY WITH THE REQUIREMENTS OF SUBPART E THAT APPLY TO THE COVERED ENTITY IN THE PERFORMANCE OF SUCH OBLIGATION(S); AND

- I. MAKE ITS INTERNAL PRACTICES, BOOKS, AND RECORDS AVAILABLE TO THE SECRETARY FOR PURPOSES OF DETERMINING COMPLIANCE WITH THE HIPAA RULES.

C) PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

- I. BUSINESS ASSOCIATE MAY ONLY USE OR DISCLOSE PROTECTED HEALTH INFORMATION ONLY AS SPECIFIED BELOW IN SECTIONS (II) THROUGH (VII).
- II. BUSINESS ASSOCIATE MAY USE OR DISCLOSE PROTECTED HEALTH INFORMATION AS REQUIRED BY LAW.
- III. BUSINESS ASSOCIATE AGREES TO MAKE USES AND DISCLOSURES AND REQUESTS FOR PROTECTED HEALTH INFORMATION CONSISTENT WITH COVERED ENTITY'S MINIMUM NECESSARY POLICIES AND PROCEDURES.
- IV. BUSINESS ASSOCIATE MAY NOT USE OR DISCLOSE PROTECTED HEALTH INFORMATION IN A MANNER THAT WOULD VIOLATE SUBPART E OF 45 CFR PART 164 IF DONE BY COVERED ENTITY, EXCEPT FOR THE SPECIFIC USES AND DISCLOSURES SET FORTH BELOW.
- V. BUSINESS ASSOCIATE MAY USE PROTECTED HEALTH INFORMATION FOR THE PROPER MANAGEMENT AND ADMINISTRATION OF THE BUSINESS ASSOCIATE OR TO CARRY OUT THE LEGAL RESPONSIBILITIES OF THE BUSINESS ASSOCIATE.
- VI. BUSINESS ASSOCIATE MAY DISCLOSE PROTECTED HEALTH INFORMATION FOR THE PROPER MANAGEMENT AND ADMINISTRATION OF BUSINESS ASSOCIATE OR TO CARRY OUT THE LEGAL RESPONSIBILITIES OF THE BUSINESS ASSOCIATE, PROVIDED THE DISCLOSURES ARE REQUIRED BY LAW, OR BUSINESS ASSOCIATE OBTAINS REASONABLE ASSURANCES FROM THE PERSON TO WHOM THE INFORMATION IS DISCLOSED THAT THE INFORMATION WILL REMAIN CONFIDENTIAL AND USED OR FURTHER DISCLOSED ONLY AS REQUIRED BY LAW OR FOR THE PURPOSES FOR WHICH IT WAS DISCLOSED TO THE PERSON, AND THE PERSON NOTIFIES BUSINESS ASSOCIATE OF ANY INSTANCES OF WHICH IT IS AWARE IN WHICH THE CONFIDENTIALITY OF THE INFORMATION HAS BEEN BREACHED.
- VII. BUSINESS ASSOCIATE MAY PROVIDE DATA AGGREGATION SERVICES RELATING TO THE HEALTH CARE OPERATIONS OF THE COVERED ENTITY.

CI) PROVISIONS FOR COVERED ENTITY TO INFORM BUSINESS ASSOCIATE OF PRIVACY PRACTICES AND RESTRICTIONS

- I. COVERED ENTITY SHALL NOTIFY BUSINESS ASSOCIATE OF ANY LIMITATION(S) IN THE NOTICE OF PRIVACY PRACTICES OF COVERED ENTITY UNDER 45 CFR 164.520, TO THE EXTENT THAT SUCH LIMITATION MAY AFFECT BUSINESS ASSOCIATE'S USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION.
- II. COVERED ENTITY SHALL NOTIFY BUSINESS ASSOCIATE OF ANY CHANGES IN, OR REVOCATION OF, THE PERMISSION BY AN INDIVIDUAL TO USE OR DISCLOSE HIS OR HER PROTECTED HEALTH INFORMATION, TO THE EXTENT THAT SUCH CHANGES MAY AFFECT BUSINESS ASSOCIATE'S USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION.
- III. COVERED ENTITY SHALL NOTIFY BUSINESS ASSOCIATE OF ANY RESTRICTION ON THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION THAT COVERED ENTITY HAS AGREED TO OR IS REQUIRED TO ABIDE BY UNDER 45 CFR 164.522, TO THE EXTENT THAT SUCH RESTRICTION MAY AFFECT BUSINESS ASSOCIATE'S USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION.

CII) PERMISSIBLE REQUESTS BY COVERED ENTITY

- I. COVERED ENTITY SHALL NOT REQUEST BUSINESS ASSOCIATE TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION IN ANY MANNER THAT WOULD NOT BE PERMISSIBLE UNDER SUBPART E OF 45 CFR PART 164 IF DONE BY COVERED ENTITY. [INCLUDE AN EXCEPTION IF THE BUSINESS ASSOCIATE WILL USE OR DISCLOSE PROTECTED HEALTH INFORMATION FOR, AND THE AGREEMENT INCLUDES PROVISIONS FOR, DATA AGGREGATION OR MANAGEMENT AND ADMINISTRATION AND LEGAL RESPONSIBILITIES OF THE BUSINESS ASSOCIATE.

CIII) TERM AND TERMINATION

- I. TERM. THE TERM OF THIS AGREEMENT SHALL BE EFFECTIVE AS OF THE LATER OF THE TWO SIGNATURE DATES BELOW, AND SHALL TERMINATE ON THE DATE COVERED ENTITY TERMINATES FOR CAUSE AS AUTHORIZED IN PARAGRAPH (II) OF THIS SECTION, WHICHEVER IS SOONER.

- II. TERMINATION FOR CAUSE. BUSINESS ASSOCIATE AUTHORIZES TERMINATION OF THIS AGREEMENT BY COVERED ENTITY, IF COVERED ENTITY DETERMINES BUSINESS ASSOCIATE HAS VIOLATED A MATERIAL TERM OF THE AGREEMENT [AND BUSINESS ASSOCIATE HAS NOT CURED THE BREACH OR ENDED THE VIOLATION WITHIN THE TIME SPECIFIED BY COVERED ENTITY]. [BRACKETED LANGUAGE MAY BE ADDED IF THE COVERED ENTITY WISHES TO PROVIDE THE BUSINESS ASSOCIATE WITH AN OPPORTUNITY TO CURE A VIOLATION OR BREACH OF THE CONTRACT BEFORE TERMINATION FOR CAUSE.
- III. OBLIGATIONS OF BUSINESS ASSOCIATE UPON TERMINATION.
  - A. UPON TERMINATION OF THIS AGREEMENT FOR ANY REASON, BUSINESS ASSOCIATE SHALL RETURN TO COVERED ENTITY [OR, IF AGREED TO BY COVERED ENTITY, DESTROY] ALL PROTECTED HEALTH INFORMATION RECEIVED FROM COVERED ENTITY, OR CREATED, MAINTAINED, OR RECEIVED BY BUSINESS ASSOCIATE ON BEHALF OF COVERED ENTITY, THAT THE BUSINESS ASSOCIATE STILL MAINTAINS IN ANY FORM. BUSINESS ASSOCIATE SHALL RETAIN NO COPIES OF THE PROTECTED HEALTH INFORMATION.
  - B. (D) SURVIVAL. THE OBLIGATIONS OF BUSINESS ASSOCIATE UNDER THIS SECTION SHALL SURVIVE THE TERMINATION OF THIS AGREEMENT.

G) MISCELLANEOUS

- I. REGULATORY REFERENCES. A REFERENCE IN THIS AGREEMENT TO A SECTION IN THE HIPAA RULES MEANS THE SECTION AS IN EFFECT OR AS AMENDED.
- II. AMENDMENT. THE PARTIES AGREE TO TAKE SUCH ACTION AS IS NECESSARY TO AMEND THIS AGREEMENT FROM TIME TO TIME AS IS NECESSARY FOR COMPLIANCE WITH THE REQUIREMENTS OF THE HIPAA RULES AND ANY OTHER APPLICABLE LAW.
- III. INTERPRETATION. ANY AMBIGUITY IN THIS AGREEMENT SHALL BE INTERPRETED TO PERMIT COMPLIANCE WITH THE HIPAA RULES.

IN WITNESS WHEREOF, THE PARTIES HAVE CAUSED THIS AGREEMENT TO BE EXECUTED AS OF THE LATER OF THE TWO DATES BELOW.

**PRODUCER**

**SIGNATURE:** \_\_\_\_\_

**PRINTED NAME:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**PRODUCER'S AFFILIATED AGENCY**

**INSMAX INURANCE BROKERAGE, INC.**

**SIGNATURE:** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_

**PRINTED NAME:** \_\_\_\_\_

**PRINTED NAME:** Lawrence Koresko

**TITLE:** \_\_\_\_\_

**TITLE:** President /General Agent

**DATE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_