GoldenCare
Planning Today For A Secure Tomorrow

AN INTEGRITY COMPANY

Thank You for Contracting with GoldenCare
Your Success Is Our Priority

In order to keep our records current, and because 90 days has elapsed since you submitted your contracting paperwork, we ask that you review and sign the following statement & authorization.

(*New Agents: please visit www.goldencareagent.com and complete our full Contracting Made Easy packet.*)

I hearby certify that the answers I provided on the Background Information Questionnaire have ❑ **changed*** ❑ **not changed** since the date I signed the form.

* *If "Changed," Please provide details on a separate sheet of paper with your printed name and signature.*

Name: (Please Print) _____

Last Four Of SSN: _____ Phone: _____ Resident State: _____

Email: _____

Agency: (If Applicable) _____

Name of Upline Manager (If Applicable): _____

Business Address: _____

Home Address: _____

Signature: _____ Date: _____

❑ Please Expedite: New Business Being Taken/Submitted:

Application Date: _____ Client Resident State: _____ Application Sign-In State: _____

Carrier/Type of Policy: _____ Client Name: _____

Non-Resident State(s) to be included on contract: _____

Please use these checkboxes to ensure you are contracted with ALL carriers of your choice:

(Please select at least one)

❍ **Mutual of Omaha and Affiliates** ❑ LTC*† ❑ MS/Dental ❑ PDP* ❑ CHS/DI* ❑ AccDeath ❑ Living Promise FE ❑ UL ❑ IUL*† ❑ IULE*† ❑ TLA* ❑ TLE ❑ GULE ❑ CWL ❑ Annuities*

❍ **Thrivent**** † (LTC)

❍ **National Guardian Life (NGL)** ❑ LTC*† ❑ Funeral Trust

❍ **OneAmerica/State Life** (Hybrid)

❍ **Securian**** ❑ Secure Care † ❑ Eclipse Protector IUL

❍ **Guarantee Trust Life** ❑ Critical Cash/Care ❑ HHC ❑ STC ❑ HI ❑ CHS ❑ CLS ❑ FE ❑ SBSA ❑ MS

❍ **True Freedom** (HHC Service Contracts)

❍ **Aetna Affiliates/CVS Health/Accendo**

❍ **Cigna**

❍ **Great Western Insurance Company**

❍ **Humana** ❑ MA ❑ MS

❍ **Lumico** (MS)

❍ **Medica***

❍ **SureBridge*** (DVH)

❍ **Union Security** (MS)

❍ **United Healthcare*** *(Requires UHC background questions)*

❍ **Washington National** (CI)

❍ **Other:** _____

* *$1,000,000 E & O Required* ** *$1,000,000 E & O Required/Provide Proof of Coverage* † *Requires Compliance with LTCi Partnership*

Abbreviations: *"LTC" Long-Term Care, "MS" Med Supp, "STC" Short-Term Care, "HHC" Home Health Care, "DI" Disability Income, "HI" Hospital Indemnity, "CI" Critical Illness, "FE" Final Expense, "CHS" Cancer/Heart/Stroke, "CLS" Cancer Lump Sum, "CWL" Childrens Whole Life, "DVH" Dental/Vision/Hearing, "SBSA" Selected Benefit Services Association.*

Please fax this form to 866-863-8608, email to: contracting@goldencareusa.com,
Or mail to: GoldenCare, 10700 Old County Road 15, Suite 450, Plymouth, MN 55441

If you have any questions, please contact us at 800-842-7799.

REQUIRED SIGNATURE

Please sign in the center of the box below.

AGENT NAME: _____ DATE: _____

(PRINT NAME HERE)

SIGNATURE AUTHORIZATION

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

I, _____, hereby authorize and direct GoldenCare USA LLC, National Independent Brokers LLC and American Independent Marketing, LLC (each an "Agency" and together the "Agencies"), each insurance carrier insurance carrier with which they contract (each a "Carrier" and together, the "Carriers") and any third party operating a portal used for contracting ("Third Parties," and together with the Agencies and Carriers, collectively, 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, agreements and other related instruments ("Appointment Forms") of any Carrier requested by me in writing, for purposes of, and in furtherance of, obtaining such Carrier's appointment and authorization permitting me to sell its products (the "Initial Purpose"), and to continue, on my behalf thereafter, all activity relevant to post-appointment administrative and sales-related processes for purposes of, and in furtherance of, selling such Carriers' products (the "Secondary Purpose" and together with the Initial Purpose, the "Purposes"), including affixing my signature to any and all required signature fields on forms, agreements and other related instruments in furtherance of the Secondary Purpose ("Administrative Forms"). My signature will not be used by the Authorized Parties for any purpose other than the Purposes.

In connection with the Purposes of becoming authorized to sell and selling Carrier insurance products, the Authorized Parties shall be permitted to create a personal User ID and Password (which the Authorized Parties will provide to me upon my request), complete and submit all such Appointment Forms and Administrative Forms to achieve the foregoing Purposes (each of which will be furnished to me upon my request following its execution for my records to the extent in the possession of an Agency, or, if not in the possession of an Agency, each of which may be provided to me upon Agency's commercially reasonable efforts to obtain such Appointment Forms and Administrative Forms from the requisite Carrier). By my signature below, I hereby agree that execution on the foregoing Appointment Forms and Administrative Forms of any Carrier by the Authorized Parties shall be binding upon me and have the same effect as if I directly executed such forms, agreements or instruments. I hereby release, indemnify and hold harmless the Authorized Parties against any and all claims, demands, losses, damages, and cause of action, including expenses, costs and reasonable attorneys' fees which may be sustained or incurred as a result of its reliance on any of the Appointment Forms or Administrative Forms bearing my signature pursuant to the authorization granted hereunder.

By my signature below, I certify that the supporting background information I have submitted to the Authorized Parties, including as provided to you on the attached Background Information Questionnaire, is complete and correct to the best of my knowledge. I understand that such information is valid for 90 days from the date hereof, and that after such period, I may be contracted to update any applicable information.

I hereby acknowledge that I have had the opportunity to consult with independent legal counsel regarding any questions I may have about this authorization page prior to my execution thereof.

REQUIRED SIGNATURE:
PLEASE SIGN YOUR NAME IN THE CENTER OF THE BOX BELOW.

Please use BLACK ink.