WellCare Health Plans, Inc.
1099 Application for Certification to market products
Certification Year 2011

Name (* denotes required field)

*First:	Middle Initial:	*Last:	Suffix (Jr, Sr):
*Email Address:			
		LMS Id:	

Personal Data

*Driver's License #:	*Date of Birth:	*SSN:

Contact Information

*Home Phone:
*Work Phone:
Mobile Phone:
Additional Phone (800#, Fax if applicable):

Address

	*Address	*City	*ST	*Zip
Home Address (NO PO BOX)				
Business Address (NO PO BOX) ☐ Same As Home				
Shipping Address ☐ Same As Hm/Bus				

Producer Insurance License Information

*Resident State:	*Resident ST License#
Other Marketing State:	Other ST License #:

FMO Confirmation

FMO Name:

Company Information

*Select how you will be contracting.

☐ Individual / Sole Proprietor	☐ Corporation	☐ Partnership	☐ Other

Please note that by selecting a company you are authorizing WellCare to remit payment for services to this company. In order to receive payment for services a W9 and Supplier Registration Form must also be submitted and are included in this application package.

Only complete the highlighted information requested below if you are contracting as a Sole Proprietor, Corporation, Partnership or Other.

Business Licensure Information

*Business State:	*Business State License#
LLC or LLP Name:	FEIN (tax id):
Sole Proprietor Name (d/b/a):	SSN/FEIN (tax id):
Corporation/Partnership Name:	FEIN (tax id):

☐ *I hereby represent and warrant to WellCare that I am an authorized officer, partner, attorney in fact, or other agent with authority to bind the above named entity. I hereby personally guarantee any agreement that may be entered into between the above named entity and WellCare. I understand and agree that WellCare is reasonably relying on my representation, warrant and guarantee, and that my guarantee is a material inducement to WellCare agreeing to enter into any agreement with the above named entity. Absent any representation and warranty, WellCare will not enter into any agreement with the entity named above.

*Company Agent Name (print):
(not required if contracting as an individual)

*Signature & Date:
(not required if contracting as an individual)

All individuals are required to complete certification each year prior to marketing WellCare's products and services. You shall not conduct any marketing or other activities related to WellCare prior to being notified by WellCare that your agreement has been accepted and your certification is complete. Certification will require the individual listed on this application to complete training and allow WellCare to conduct a full background check at various times throughout the year as well as complete appointments to each state department of insurance where applicable.

I have read the Producer Agreement, understand its terms, and I am indicating my agreement to be bound by signing below.

*Signature: _____ *Date: _____