

Physician Health Choice Ethical Sales & Marketing Agreement

I certify that as an Authorized Independent Broker of Physicians Health Choice, I have read and agree to abide by the following Ethical Sales and Marketing Guidelines and Practices. I understand that any violation of this agreement may result in legal and contractual sanctions against me and/or my Agency.

(Please initial each line)

- _____ Only qualified Medicare beneficiaries residing in approved service areas may be enrolled.
- _____ All information about PHC must be presented in a full, fair, and accurate manner. Activities that could mislead or confuse potential members about the CMS policies or the PHC products are prohibited.
- _____ Written information regarding PHC benefit packages including grievances and appeals procedures and disenrollment rules and rights must be provided. These are to be explained in detail to each potential enrollee.
- _____ A clear and full explanation of the Lock-In requirement, (use of contracted Providers) including proper description of both emergency and urgent care must be provided during enrollment.
- _____ CMS and company's Regulatory Compliance Department must review and approve all marketing materials and correspondence including those not developed by PHC but used on PHC's behalf.
- _____ Activities, that may cause potential enrollees to feel pressured, impelled, or coerced to enroll in any way, are prohibited.
- _____ Representation by an Authorized Independent Broker as an agent of Medicare, the federal government (i.e., Social Security office) or any organization other than PHC is prohibited.
- _____ Offering gifts or payments to induce enrollment is prohibited.
- _____ Door-to-Door solicitation and outbound telemarketing are prohibited.
- _____ Any statements, claims, or promises, whether written or expressed orally that conflict with, materially alter, or erroneously expand upon the information contained in CMS approved materials are forbidden.

- _____ Using the option to “cancel or disenroll if not fully satisfied” or “enroll on a trail basis” as a selling/closing technique is prohibited.
- _____ Authorized Independent Brokers must abide by all PHC and CMS regulations, policies, procedures and practices.
- _____ PHC adheres to the tenants set forth in Title VI of the Civil Rights Act of 1965 and does not discriminate against any individual on the basis of race, creed, color, sex, age, national origin and/or health status.
- _____ Only competent individuals may enroll. Forgery or acceptance of a signature other than the enrollee or his designated legal representative is strictly prohibited.
- _____ Proper use of the Scope of Appointment form or Attestation Verification Record Call is mandatory per CMS Marketing Guidelines.

Acknowledgement

Agent Name Signature

Agent Name – Print

Date

Physician Health Choice (PHC)
Medicare Advantage (MA)
Agent/Broker Training Confirmation

(Please initial each line)

- _____ I have successfully completed AHIP or CMS certification training course.
- _____ I have successfully completed the PHC Medicare Advantage Agent/Broker Certification course and have passed the PHC MA Certification Exam.
- _____ I have been given training and fully understand PHC MA plans, including benefits and limitations and agree to give a full disclosure of all plan benefits and limitations in every PHC sales presentation.
- _____ I have been given training and fully understand the PHC's Ethical Marketing Requirements.
- _____ I have been given training and fully understand CMS prohibited marketing activities.
- _____ I understand and agree to only use CMS and PHC approved marketing literature, communications and advertisements when describing PHC's MA plan benefits to eligible beneficiaries.
- _____ I understand that door-to-door solicitation and/or Cold-Calling for purposes of enrolling or obtaining referrals for PHC's MA plans is prohibited.
- _____ I have understand a copy of the current Medicare Marketing Guidelines as well as those outlined in Chapter 3 of the Medicare Managed Care Manual and the new MIPPA Guidelines for Marketing is available on the PHC Broker Portal.
- _____ I understand that only fully competent eligible beneficiaries or their legal guardians/POA may enroll in PHC's MA plans.
- _____ I understand and agree that I will not discriminate against eligible beneficiaries based on age, health status, race, ethnicity, or religion.

My signature below acknowledges that I have been trained and agree to comply with Physicians Health Choice plan policies and procedures, CMS marketing regulations and the States of: Texas, New Mexico, Arkansas & Florida Department of Insurance laws and regulations.

Signature

Date

**Medicare Advantage (“MA”)
Sub-level Agent Agreement (“Agreement”)**

In consideration of the training provided to me and the appointment and continued appointment of me by Physicians Health of Texas, LLC (“Company”) as an Independent Agent, I am entering into this Agreement as of the last date written below.

I make the following representations and agree to comply with the following obligations:

1. I represent that I have no legal obligations inconsistent with this Agreement, and I hold a currently valid Life, Accident and Health License from the Texas Department of Insurance (“TDI”). I understand that I may not market, solicit or enroll eligible beneficiaries in Company’s MA plans unless such license is current.
2. I have been given training and fully understand Medicare eligibility guidelines, election periods and coverage.
3. I have been given training and fully understand Company MA plans, including benefits and limitations, and agree to give a full disclosure of all plan benefits and limitations in every Company sales presentation.
4. I understand that all information about Company must be presented in a full, fair, and accurate manner. I agree not to engage in activities that could deceive, mislead or confuse potential enrollees about, or misrepresent the benefits of, the Centers for Medicare and Medicaid Services (“CMS”) policies or Company’s products.
5. I agree to explain in detail and provide to each potential enrollee written information regarding Company benefit packages, including grievances and appeals procedures and disenrollment rules and rights.
6. I agree to fully and clearly explain to each potential enrollee during enrollment the “Lock-In” requirement, including proper utilization of emergency and urgent care.
7. I understand and agree that I must provide the following disclosure, prior to enrollment or at the time of enrollment, in writing, to all eligible beneficiaries:

“The person that is discussing plan options with you is an agent of [name of Agency] and is contracted with the Physicians Health Choice plan. The person may be compensated based upon your enrollment in a plan.”
8. I understand that it is my responsibility to complete annual recertification training for Company MA plans and to attend any future educational, training and/or certification seminars that Company may offer and require with respect to the Company MA plans. I further understand that I will not be eligible to receive Renewal Commissions unless I meet this requirement.
9. I agree to maintain complete records of all solicitations and eligible beneficiary membership applications, along with all other records required to be maintained by me, for a period of ten years after my termination as an agent for Company.
10. I agree to provide Company with at least five days advance written notice of any change in my address or email address.
11. I understand and agree to use only CMS and Company approved marketing literature, communications and advertisements when describing Company’s MA plan benefits to eligible beneficiaries, and I shall not alter such marketing materials in any fashion other than to insert my contact information as permitted by Company.
12. I agree to report to Company immediately if I become aware of any unlicensed insurance activity or solicitation activities for the solicitation and enrollment of eligible Medicare beneficiaries that are inconsistent with the training I received in Company’s certification course.

13. I have received a current copy of and fully understand the Medicare Marketing Guidelines.
14. I understand and agree that CMS and Company's Regulatory Compliance Department must review and approve all marketing materials prior to use, publication, distribution or field implementation.
15. I have been given training and fully understand CMS prohibited marketing activities. I understand that the following marketing activities are prohibited by Company:
 - a. I agree not to engage in activities that may cause potential enrollees to feel pressured, impelled, or coerced to enroll in any way.
 - b. I agree not to disparage competitors, their products or services, or use any other unfair methods of competition or deceptive acts toward Company's competitors in an effort to cause potential enrollees to enroll.
 - c. I agree not to represent that I am an agent of Medicare, the federal government (e.g. Social Security office) or any organization other than Company.
 - d. I agree not to engage in Door-to-Door solicitation.
 - e. I agree not to engage in telemarketing activities prohibited by applicable federal and/or state laws or regulations, including DO NOT CALL legislation.
 - f. I agree not to make any statements, claims, or promises, whether written or expressed orally, that conflict with, materially alter, or erroneously expand upon the information contained in CMS- or Company- approved materials.
 - g. I agree not to use the option to "cancel or disenroll if not fully satisfied" or "enroll on a trial basis" as a selling/closing technique.
 - h. I understand that only competent individuals may enroll, and that I may not use forgery or accept a signature other than that of the enrollee or his or her designated legal representative, legal guardian or attorney-in-fact.
 - i. I understand that it is prohibited to offer gifts, payments, or any other form of remuneration to prospective enrollees as an inducement to enroll in Company's MA plan.
 - j. I understand and agree that I will only solicit and enroll qualified Medicare beneficiaries residing in approved service areas.
 - k. I understand and agree that I will not use any confidential or proprietary materials belonging to any other person or entity in soliciting or enrolling Medicare beneficiaries in Company's MA plans.
16. I agree to abide by: (i) applicable CMS MA and/or Part D laws; (ii) all other applicable Federal health care laws rules and regulations (including civil monetary penalty laws); (iii) CMS policies including CMS's marketing guidelines; and (iv) all other state applicable laws, rules and regulations. To the extent such authorities are inconsistent with any provision set forth herein, the statutes, regulations, guidelines and instructions shall prevail, and I shall comply therewith. Further, I agree to comply with all Company policies and procedures, as such may be revised from time to time, which policies and procedures will be posted on Company's website and made available in writing upon request.
17. I understand that Company adheres to the tenets set forth in Title VI of the Civil Rights Act of 1965, and I agree not to discriminate against any individual on the basis of race, creed, color, sex, age, national origin and/or health status (except for End-Stage Renal Disease).
18. I agree to fully cooperate with Company in any review or investigation that Company undertakes with respect to any of its agents, or in any review or investigation conducted by a third party, including without limitation TDI and CMS. I shall permit Company and any federal or state governmental officials with regulatory

authority over me, at any time, to examine my books, records and information systems in order to verify my compliance with this Agreement. I agree to cooperate fully with Company as Company may request or direct, including allowing such personnel to conduct the examination during normal business hours and in a manner that does not materially disrupt my business operations.

19. I understand that the payment of any commissions or compensation shall be subject to and paid in accordance with the terms of CMS rules, regulations and guidelines then in effect, as well as the terms and conditions contained in this Agreement and Company's policies and procedures, which terms shall include the following:
 - a. Company will pay me the Initial Year Commission and the Renewal Commissions described in the attached Schedule 19 (together, the "**Fee**") for each Prospective Enrollee that I enroll into Company's Medicare Advantage plans. Except as provided below, Company shall pay me the Initial Year Commission (as defined on Schedule 19) for each Prospective Enrollee who is either enrolling in a Medicare Advantage plan for the first time or who is making an Enrollment Change (as defined by CMS) during the six-year commission payout cycle (the "**Commission Cycle**") applicable to such Prospective Enrollee. Except as provided below, Company shall pay me a Renewal Commission (as defined on Schedule 19) for each of the remaining years of the Commission Cycle, or such shorter period that the Prospective Enrollee remains enrolled in Company's Medicare Advantage plans. The Fee in effect at the time a Prospective Enrollee enrolls shall remain in effect with respect to such Prospective Enrollee for the entire Commission Cycle unless and until the Prospective Enrollee makes an Enrollment Change.
 - b. If I shall (i) have my license revoked, suspended or not renewed, or (ii) terminate or have terminated my appointment with Company for any reason, then Company shall pay me the Fees earned through the effective date of termination as provided in this Section 19(a)(iv), and no further Fees shall be due to me thereafter. Company reserves the right to re-classify Initial Year Commissions as Renewal Commissions, and vice versa, if it is so directed by CMS, and to offset any amounts due to or from me in later periods with respect to such reclassifications. Company reserves the right to adjust my Initial Year Commissions or Renewal Commissions, as applicable, to comply with CMS regulations. Notwithstanding anything herein to the contrary, if I shall cause a Prospective Enrollee to replace a Like Plan with Company's Medicare Advantage plans during the Commission Cycle applicable to the Prospective Enrollee, I shall only be entitled to Renewal Commissions during the remainder of the Prospective Enrollee's Commission Cycle, or such shorter period that the Prospective Enrollee remains enrolled in Company's Medicare Advantage plans. If Company pays any Fee to me for a Prospective Enrollee who disenrolls at any point during the Commission Cycle, I shall promptly refund the unearned Fee, or such prorated portion thereof, as applicable, or Company may offset the unearned Fee paid from any other Fees due to me under this Agreement.
 - c. In no event will I be entitled to any compensation from Company relating to the business, products or performance of services by Company. I will bear all of my own expenses without recourse to Company.
 - d. If I incur indebtedness to Company, including indebtedness related to commission advances, Company may offset such indebtedness against, and deduct such indebtedness from, any Fees due to me hereunder. I agree such indebtedness shall be a first lien against all such Fees.
20. I understand that Company has no obligation to accept any application received from me or to continue any enrollment of an enrollee already accepted by Company whom I enrolled.
21. I am an independent contractor of the Agency (as hereinafter defined). In the event that I elect to terminate my relationship with the Agency, I will provide Company with thirty (30) days advance written notice.
22. I am an independent contractor. I will not represent myself to be an employee of Company.

23. I agree that the failure of either party to require the performance of any term of this Agreement will not prevent a subsequent enforcement of the term nor be deemed a waiver of any subsequent breach.
24. I recognize that during the term of this Agreement, I will develop and/or may be exposed to information which is confidential or proprietary to Company or its affiliates, including, but not limited to, this Agreement, the names and addresses of Company's current enrollees and prospective enrollees; lead lists; pricing; marketing materials and methodologies; proposals; data; reports; lists; records; business practices and locations; software; documentation in any media; Company's relationship with its agents, enrollees, employees, suppliers, contractors or prospective relationships with any of the foregoing; contracts of any type or nature; marketing and business plans; financial information and similar items; and all non-public information of any type regardless of how provided to or stored by me ("**Confidential Information**"). I acknowledge that I may only use the Confidential Information in connection with the solicitation and enrollment of prospective enrollees in Company's MA health plan, and I may not use, disclose or otherwise ever make the Confidential Information available to any person other than Agency and Company, nor will I ever use any Confidential Information to compete with Company. Upon the termination of this Agreement for any reason, I will immediately remove all Confidential Information from my computer systems and storage devices and return such Confidential Information to Agency or Company and cease the use of all Confidential Information (including, but not limited to, all electronic copies thereof) provided to me.
25. I agree to indemnify and hold Company and its affiliates and their respective members, managers, shareholders, officers, directors, employees, attorneys and agents harmless from and against any and all claims, damages, costs, losses and expenses, including, but not limited to, reasonable attorneys' and investigative fees and litigation expenses (at both trial and appellate levels), incurred by Company and/or its affiliates by reason of any alleged or actual breach of this Agreement by, or any alleged or actual acts or omissions by me with respect to this Agreement, including, but not limited to, alleged or actual breaches by me of any non-competition or non-solicitation agreements to which I am a party. The provisions of this Section 24 shall survive the expiration or termination of this Agreement.
26. The parties agree that any controversy or claim (whether such controversy or claim is based upon a statute, contract, tort or otherwise) arising out of or relating to this Agreement, any performance or dealings between the parties, or any dispute arising out of the interpretation or application of this Agreement, which the parties are not able to resolve, will be settled exclusively by arbitration in San Antonio, Texas by a single arbitrator pursuant to the American Arbitration Association's Commercial Arbitration Rules then existing, and judgment upon the award rendered by the arbitrator will be entered in any court having jurisdiction thereof. The arbitrator will be chosen from a panel of licensed attorneys, each of whom shall have at least 15 years of professional experience, and be familiar with the regulation of insurance agents by TDI and CMS, the solicitation of prospective Medicare beneficiaries and the subject matters addressed in this Agreement. The arbitrator will be appointed within 30 days of the date the demand for arbitration was sent to the other party. The arbitrator will have the authority to grant injunctive relief in a form similar to that which a court of law would otherwise grant.
27. If any provision of this Agreement becomes or is declared by a court of competent jurisdiction to be illegal, unenforceable or void, this Agreement shall continue in full force and effect without said provision; provided that no such severability shall be effective if it materially changes the economic benefit of this Agreement to any party.
28. This Agreement may only be amended from time to time through a written instrument signed by both Company and me; provided, however, I agree that Company reserves the right to modify or amend this Agreement upon five business days written notice to me. My failure to object to such modification during the five business day notice period shall constitute my acceptance of such modification. If I object to such modification or amendment, notwithstanding any provision in this Agreement to the contrary, Company may terminate this Agreement upon ten days written notice to me following Company's receipt of my objection or refusal to agree to any amendment. Company reserves the right to add or delete products, and change characteristics of each product at any time, from time to time, and without notice. In the event that Company deems it necessary or desirable to amend this Agreement in order to comply with changes in the law or regulations of the State of Texas and/or of the United States of America, including, but not limited to TDI and/or CMS, Company shall furnish me with written notice of the amendment it deems necessary or

desirable, and I shall automatically be bound by such amendment without any additional action, documentation or signature.

- 29. IN NO EVENT WILL Company BE LIABLE FOR ANY INCIDENTAL, CONSEQUENTIAL, SPECIAL, PUNITIVE OR INDIRECT DAMAGES OF ANY KIND, INCLUDING, WITHOUT LIMITATION, LOST BUSINESS PROFITS RELATING TO THIS AGREEMENT OR THE TERMINATION OF THIS AGREEMENT.
- 30. I agree that this Agreement shall become effective when signed by myself and Company, and shall continue unless and until terminated by either party. This Agreement may be terminated by me or Company with or without cause upon ten (10) days written notice to either party, effective upon the expiration of the notice period. This Agreement shall automatically terminate if my license is revoked, suspended or not renewed and, in such event, I will immediately cease providing services or solicitations on behalf of Company. I agree that I will immediately provide written notice to Company of such revocation, suspension or non-renewal, and this Agreement shall automatically be immediately terminated without further action on the part of Company. Termination shall not relieve me of my obligations under this Agreement that arose prior to termination. Upon termination, I will promptly return to Company all policy forms, property, records or other materials furnished to me by Company or Agency and shall cease the use of and destroy or return all Confidential Information. Company shall not be liable to me on account of the termination, cancellation, or expiration of this Agreement, either for compensation for damages of any kind or character whatsoever, or on account of the loss of present or prospective profits on sales or anticipated sales, goodwill, or expenditures, investments or commitments made in contemplation or anticipation of this Agreement or any transaction expected under it.
- 31. This Agreement is made in and will be construed in accordance with the laws of the United States and the State of Texas applicable to contracts made and to be performed in Texas. Each party agrees to submit itself to the jurisdiction of the courts in Bexar County, Texas to enforce the arbitration provisions of this Agreement. Both parties agree that any previous agreement between the parties relating to the subject matter of this Agreement will terminate automatically on the effective date of this Agreement, without further action by either party. Neither I nor Company will be bound by any oral agreement or representation relating to the subject matter of this Agreement, irrespective of by whom or when made. This Agreement may be executed in multiple counterparts, each of which will be deemed to be an original, and all counterparts will constitute one instrument.

IN WITNESS WHEREOF, the parties hereto, intending to be legally bound, have executed this Agreement as of the last date written below.

Physicians Health Choice of Texas, LLC

**Independent Agent,
an independent contractor of The Copeland Group
("Agency")**

By: _____

Signature

Printed Name: _____

Printed Name: _____

Date: _____

Date: _____

Address: _____

Phone Number: _____

SCHEDULE 19

COMPENSATION FOR ENROLLEES

I will be compensated as follows for application(s) being accreted (approved by CMS):

Texas Membership

- All products

“Initial Year Commission” \$403

“Renewal Commission” \$202/year for continued enrollment in “Like Plan” (as defined by CMS) for up to five subsequent years

Company shall make all commission payments by wire transfer or direct deposit unless otherwise agreed to by me and Company. Company shall pay the entire amount of the Initial Year Commission within seven (7) to fourteen (14) days of Company's verification of the Prospective Enrollee's information with the CMS TRR Table. Enrollment forms for Potential Enrollees must be submitted to Company within twenty-four (24) hours of execution by each Potential Enrollee. So long as the Prospective Enrollee remains enrolled in Company's Medicare Advantage plans during the remainder of the Commission Cycle, and subject to the other limitations in the Agreement, the Renewal Commissions shall be paid, as earned, on a monthly basis on or about the twenty-fifth (25th) day of each month during the remainder of the Commission Cycle.

Company shall perform periodic reconciliations of amounts paid to me hereunder. In the event such reconciliations reflect that amounts are due to me or Company hereunder, in Company's discretion, either (i) I shall promptly refund such amounts, or a prorated portion thereof, or (ii) such amounts shall be offset against future payments due to me under this Agreement.

This Schedule 19 shall remain in effect until it is revised by Company by written notice to me in which case the compensation set forth in such notice shall be effective as provided in such notice.

ADDENDUM A

HIPAA BUSINESS ASSOCIATE AGREEMENT

This HIPAA Business Associate Agreement ("**BAA**"), entered into by and between **Physicians Health Choice of Texas, LLC**, a Texas limited liability company ("**Company**"), and **The Copeland Group**, hereinafter a Business Associate ("**BA**"), supplements and is made a part of the Medicare Advantage Sub-Level Agent Agreement (the "**Agent Agreement**") entered into between Company and BA, and is effective as of the Effective Date of the Agency Agreement.

RECITALS

WHEREAS, the defined terms in the Agent Agreement have the same meaning in this BAA;

WHEREAS, Company and BA have entered into the Agent Agreement whereby BA solicits applications from Prospective Enrollees and Medicare beneficiaries into Company's Medicare Plan in accordance with Company's contract with CMS and applicable laws, which such Agent Agreement is expressly incorporated herein by reference;

WHEREAS, Company and BA wish to protect the privacy and provide for the security of certain Protected Health Information of Prospective Enrollees ("**PHI**") that may be disclosed to BA in compliance with HIPAA and HIPAA Regulations and other applicable laws;

WHEREAS, the purpose of this BAA is to satisfy certain standards and requirements of HIPAA and the HIPAA Regulations, including, but not limited to, Title 45, Section 164.504(e) of the Code of Federal Regulations, as the same may be amended from time to time; and

NOW THEREFORE, for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties, intending to be legally bound, hereby agree as follows:

1. **Definitions.** For the purposes of this BAA, the following terms have the meanings ascribed to them:

1.1 "**Disclosure**" with respect to PHI, shall mean the release, transfer, provision of access to or divulging in any other manner of PHI outside the entity holding the PHI.

1.2 "**Individual**" shall mean the person who is the subject of the PHI.

1.3 "**Parties**" shall mean Company and BA.

2. "**PHI**" shall mean any information created or received by Company, or another entity acting on Company's behalf, or by BA in the performance of its services on behalf of Company, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an Individual; the provision of health care to an Individual; or the past, present or future payment for the provision of health care to an Individual, and (ii) that identifies the Individual or with respect to which there is a reasonable basis to believe the information can be used to identify the Individual.

3. **Stated Purpose for Which BA May Use or Disclose PHI.** The Parties hereby agree that except as otherwise limited in this BAA, BA shall be permitted to use or disclose PHI provided or made available to BA from Individual or Company to perform any function, activity or service for, or on behalf of, Company as specified in the Agent Agreement or in this BAA, provided that such use or disclosure would not violate the HIPAA Regulations if done by Company. BA may make PHI available to

Company or other permitted third party via the Internet or other electronic medium in accordance with this BAA, HIPAA and the HIPAA Regulations.

4. **BA Obligations.** BA covenants and agrees that it shall:

4.1 Not further use or disclose the PHI provided or made available by Individual or Company other than for the purposes required and permitted in the Agent Agreement or by this BAA or as required by applicable law or regulation;

4.2 Establish and maintain appropriate safeguards as necessary to prevent the use or disclosure of PHI other than as permitted under the Agent Agreement and this BAA;

4.3 Report to Company any use or disclosure of PHI that BA is aware of that is not provided for or allowed by the Agent Agreement or this BAA;

4.4 Ensure that any of its agents or subcontractors, or other third parties with which BA does business that are provided PHI on behalf of Company, are aware of and bound to BA's obligations under this BAA;

4.5 Make available to Company such information as Company may require to fulfill Company's obligations to provide access to, amendment of, and account for disclosures with respect to PHI pursuant to HIPAA and the HIPAA Regulations, including, but not limited to, 45 C.F.R. §§ 164.524, 164.526, and 164.528; and

4.6 Make available to the Secretary of the U.S. Department of Health and Human Services all internal practices, books and records relating to the use and disclosure of PHI received from, received by, or created by, BA on behalf of Company, for purposes of determining Company's compliance with federal privacy laws and regulations.

5. **Permitted Disclosures.** Notwithstanding 4 above, the Parties agree that, pursuant to federal law, BA may:

5.1 Use or disclose PHI in its possession, for its proper management and administration or to fulfill any of its present or future legal responsibilities provided that: (i) such uses are permitted under state and federal confidentiality laws, (ii) the disclosures are required by law, as defined by 45 C.F.R. § 164.501, or (iii) BA has received from the third party written assurances that the PHI will be held confidentially, that the PHI will only be used or further disclosed as required by law or for the purpose for which it was disclosed to the third party, and that the third party will notify BA of any instances of which it is aware in which the confidentiality of the information has been breached, as required under 45 C.F.R. § 164.504(e)(4); and

5.2 Use PHI in its possession to provide data aggregation services relating to the health care operations of Company, as defined by 45 C.F.R. § 164.501.

6. **Termination.** Notwithstanding any other provision under the Agent Agreement and pursuant to federal law, each Party agrees that the Agent Agreement may be terminated by the other Party without penalty should the other Party violate a material obligation under this BAA.

7. **Return or Destruction of PHI.** Upon termination or expiration of the Agent Agreement, BA shall return to Company any and all PHI received from, received by, or created by, BA on behalf of Company that is maintained by BA in any form whatsoever, including any copies or replicas. If returning the PHI to Company is not feasible, BA shall destroy any and all PHI maintained by BA in any form whatsoever, including any copies or replicas. Should the return or destruction of the PHI be determined by BA to be contrary to BA's legal or operational interests or otherwise not feasible, the Parties agree that the terms of this BAA shall extend to the PHI for such time as BA deems necessary, and any further use

or disclosure of the PHI by BA shall be limited to that purpose which renders the return or destruction of the PHI infeasible.

8. **Amendment to Comply with Law.** The Parties acknowledge that state and federal laws relating to electronic data security and privacy are rapidly evolving and that amendment of this BAA may be required to provide for procedures to ensure compliance with such developments. The Parties agree to take such action as is necessary to comply with the standards and requirements of HIPAA, the HIPAA Regulations and other applicable laws relating to the security or confidentiality of PHI. Upon either Party's request, the other Party agrees to promptly enter into negotiations concerning the terms of an amendment to this BAA.

9. **Indemnification.** Each Party agrees to indemnify, defend and hold harmless the other Party, its affiliates and each of their respective directors, officers, employees, agents or assigns from and against any and all actions, causes of action, claims, suits and demands whatsoever, and from all damages, liabilities, costs, charges, debts, and expenses whatsoever (including reasonable attorneys' fees and expenses related to any litigation or other defense of any claims at both trial and appellate levels), which may be asserted or for which they may now or hereafter become subject arising in connection with: (i) any misrepresentation, breach of warranty or non-fulfillment of any undertaking on the part of the indemnifying Party under this BAA; and (ii) any claims, demands, awards, judgments, actions, and proceedings made by any person or organization arising out of or in any way connected with the indemnifying Party's performance under this BAA.

10. **No Third Party Beneficiaries.** Nothing express or implied in this BAA is intended to confer, nor shall anything herein confer, upon any person other than Company, BA, and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

11. **Term.** This BAA shall become effective on the Effective Date of the Agent Agreement and shall expire when all of the PHI provided by Company to BA is destroyed or returned to Company. In the event of a conflict between this BAA and other terms and conditions agreed to by the Parties, the terms of this BAA shall control with respect to its subject matter.

12. **Parties to Agreement.** Company and BA acknowledge and agree that they are the Parties to this BAA and to the Agent Agreement, and, to the extent such Parties are not so identified in the Agent Agreement, the Agent Agreement is hereby amended accordingly.

13. **Entire Agreement.** The Agent Agreement and this BAA, including any and all attachments, exhibits, riders, and other documents referenced herein, constitute the entire and full agreement between the Parties hereto with respect to the subject matter hereof and supersede any previous contract and no changes, amendments or alterations will be effective unless reduced to a writing signed by a duly authorized representative of both Parties. Any prior agreements, documents, understandings, or representations relating to the subject matter of this BAA not expressly set forth herein or referred to or incorporated herein by reference are of no force or effect.

[[The remainder of this page is intentionally left blank.]]

IN WITNESS WHEREOF, the Parties hereto, intending to be legally bound, have executed this BAA as of the Effective Date of the Agent Agreement.

Physicians Health Choice of Texas, LLC

Agent Name:

By: _____
Printed Name: _____
Date: _____

Signature: _____
Printed Name: _____
Title: _____
Date: _____
TID# or SS# _____
Address: _____

Phone Number: _____

Request for Taxpayer Identification Number and Certification

**Give form to the
requester. Do not
send to the IRS.**

Print or type
See Specific Instructions on page 2.

Name		
Business name, if different from above		
Check appropriate box: <input type="checkbox"/> Individual/ Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other ▶	<input type="checkbox"/> Exempt from backup withholding	
Address (number, street, and apt. or suite no.)	Requester's name and address (optional)	
City, state, and ZIP code		
List account number(s) here (optional)		

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). **However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 2.** For other entities, it is your employer identification number (EIN). If you do not have a number, see **How to get a TIN** on page 2.

Social security number								
or								
Employer identification number								

Note: If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
2. I am not subject to backup withholding because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified me that I am no longer subject to backup withholding, **and**
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 2.)

Sign Here	Signature of U.S. person ▶	Date ▶
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Purpose of Form

A person who is required to file an information return with the IRS must get your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to give your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

If you are a foreign person, use the appropriate Form W-8. See Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities.

Note: If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 30% of such payments **after** December 31, 2001 (29% **after** December 31, 2003). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will **not** be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester, or
2. You do not certify your TIN when required (see the Part II instructions on page 2 for details), or
3. The IRS tells the requester that you furnished an incorrect TIN, or
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions on page 2 and the separate **Instructions for the Requester of Form W-9.**

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name. If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first and then circle the name of the person or entity whose number you enter in Part I of the form.

Sole proprietor. Enter your **individual** name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, **enter the owner's name on the "Name" line.** Enter the LLC's name on the "Business name" line.

Other entities. Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Exempt from backup withholding. If you are exempt, enter your name as described above, then check the "Exempt from backup withholding" box in the line following the business name, sign and date the form.

Individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends. For more information on exempt payees, see the Instructions for the Requester of Form W-9.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

Note: If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

Part I—Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box.

If you are a **resident alien** and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see **How to get a TIN** below.

If you are a **sole proprietor** and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are an LLC that is **disregarded as an entity** separate from its owner (see **Limited liability company (LLC)** above), and are owned by an individual, enter your SSN (or "pre-LLC" EIN, if desired). If the owner of a disregarded LLC is a corporation, partnership, etc., enter the owner's EIN.

Note: See the chart on this page for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get **Form SS-5**, Application for a Social Security Card, from your local Social Security Administration office. Get **Form W-7**,

Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or **Form SS-4**, Application for Employer Identification Number, to apply for an EIN. You can get Forms W-7 and SS-4 from the IRS by calling 1-800-TAX-FORM (1-800-829-3676) or from the IRS Web Site at www.irs.gov.

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: Writing "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.

Part II—Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 3, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt recipients, see **Exempt from backup withholding** above.

Signature requirements. Complete the certification as indicated in 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA or Archer MSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to give your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA or Archer MSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 30% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN or:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account ¹
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor ²
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee ¹
b. So-called trust account that is not a legal or valid trust under state law	The actual owner ¹
5. Sole proprietorship	The owner ³
For this type of account:	Give name and EIN or:
6. Sole proprietorship	The owner ³
7. A valid trust, estate, or pension trust	Legal entity ⁴
8. Corporate	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

¹ List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

² Circle the minor's name and furnish the minor's SSN.

³ You must show your individual name, but you may also enter your business or "DBA" name. You may use either your SSN or EIN (if you have one).

⁴ List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.



Business Card Order Form



Authorized Broker

Name
Texas License # _____
New Mexico # _____

Phone #

Cell #

Address

Fax #

City, State, Zip

Email

AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS (ACH DEBITS)

Broker Name: _____ Broker ID # _____

I (we) hereby authorize **Physicians Health Choice**, hereinafter called COMPANY, to initiate debit entries to my (our) Checking Account indicated below at the depository financial institution named below, hereafter called DEPOSITORY. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

Depository Name _____ Branch _____

City _____ State ____ Zip _____

Routing Number _____ Accounting Number _____

This authorization is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITIORY a reasonable opportunity to act on it.

Name(s) _____
(Please print)

Date _____ Signature _____

Please include a copy of a voided check along with this form