



MEDICO CONTRACTING CHECKLIST

Name: _____

Agency: _____

- Signed Agreement & Personal History**
- Signed HIPAA Business Associate Agreement**
- Signed Acknowledgement of Receipt**
- Producer Life Replacement Policies & Procedures**
- Direct Deposit Authorization**
- Copy of Errors and Omissions Insurance**
- Copy of Producer License for each state in which to be appointed**
- Copy of agency licenses, if applicable**



CONFIDENTIAL PERSONAL HISTORY

PERSONAL INFORMATION:

Name _____ Social Security No. _____ - _____ - _____
First M.I. Last Suffix

Date of Birth _____ Sex _____ Maiden or Other Name Used _____ Spouse's Name _____

Home Address _____
Street Apt. No. City State Zip Code

Mailing Address _____
Street Apt. No. City State Zip Code

UPS Address _____
Street Apt. No. City State Zip Code

Business Phone No. (____) _____ - _____ Home Phone No. (____) _____ - _____

E-Mail Address: _____ Fax No.: (____) _____ - _____

IMPORTANT!! E-MAIL ADDRESS IS REQUIRED FOR WEBSITE SIGN ON AND FOR COMMUNICATION FROM HOME OFFICE

TYPE OF CONTRACT:

If you are seeking an appointment on behalf of an agency, is that agency a:

- Sole Proprietorship Partnership Corporation

FEDERAL I.D. NO. _____

Is the agency now licensed? YES NO

Please list all partners or corporate officers:

NAME	TITLE	SOCIAL SECURITY NO.

LICENSE INFORMATION:

Are you now licensed? YES NO

If yes, please indicate below any license(s) you currently hold:

RESIDENT STATE	LICENSE OR QUALIFICATION NO.	TYPE OF LICENSE/LINES
NONRESIDENT STATE(S)	LICENSE OR QUALIFICATION NO.	TYPE OF LICENSE/LINES

WORK HISTORY:

(Please begin with most current employer.)

EMPLOYER/ADDRESS	SUPERVISOR NAME	POSITION HELD	DATES	PHONE NUMBER
			FROM TO	(____) ____-____ Ok to contact? _____
			FROM TO	(____) ____-____ Ok to contact? _____
			FROM TO	(____) ____-____ Ok to contact? _____

28. This Agreement is effective _____, 20__.

Accepted, agreed to and signed by the parties:

1. Distributor's Name _____
(Please Print)

Taxpayer I.D. or Social Security Number

2. Distributor is: Individual (Sole Proprietor) ()
Partnership ()
Corporation ()

IF DISTRIBUTOR IS INDIVIDUAL OR SOLE PROPRIETOR:

BY: _____
(Signature)

IF DISTRIBUTOR IS PARTNERSHIP: (all partners must sign)

BY: _____
(Signature) (Printed Name)

BY: _____
(Signature) (Printed Name)

BY: _____
(Signature) (Printed Name)

IF DISTRIBUTOR IS CORPORATION:

BY: _____
(Signature & Title of Authorized Officer) (Printed Name)

Recommended By:

Accepted:
MEDICO® INSURANCE COMPANY

Drennan Insurance Marketing, Inc.
1501 N. University, Ste. 551
Little Rock, AR. 72207

By _____
Title Michael J. Leahy, Secretary

- c. Survival. The respective rights and obligations of Business Associate under Section c "Effect of Termination" of this Agreement shall survive the termination of this Agreement.
- d. Interpretation. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule.

The undersigned on behalf of himself, the partnership, or corporation is executing this Agreement solely in reliance upon his own knowledge, belief and judgment, and not upon any representations made by the Covered Entity or others on its behalf.

I have read the foregoing Agreement and understand its terms and freely and voluntarily sign.

Dated at _____, this _____ day of _____, 20_____.

(Signature)

(Name)

(Title)

(Individual, Partnership or Corporation Name)



MEDICO™ GROUP

*Medico™ Insurance Company
Medico™ Life Insurance Company
1515 South 75th Street • Omaha, Nebraska 68124*

**ACKNOWLEDGEMENT OF RECEIPT
PRODUCER LIFE REPLACEMENT POLICIES AND PROCEDURES**

I acknowledge that I have received, read and will adhere to the guidelines stated in the Producer Life Replacement Policies and Procedures for Medico™ Insurance Company and Medico™ Life Insurance Company, Form U9F-4240. I understand that violating any of the stated policies or procedures will subject me to sanctions up to and including termination of appointment.

I am aware that I will not be eligible to solicit life insurance for the Company if this acknowledgement is not returned to the Company. When completed, please return this acknowledgement to: Marlene Albertsen, Manager of Agent Services, Medico™ Group, 1515 South 75th Street, Omaha, NE 68124. You may also fax the form to: Marlene Albertsen at (402) 398-0887.

Print Name

Producer Number

Agency Name (if applicable)

Date

Original Signature