How To Mail Your Contract
Licensing Procedure
For HealthSpring Insurance Company

Please complete and return the following:

☐**Copies of valid licensing for each market you intend to sell in**

☐**A copy of your E&O policy/coverage**

☐**Hierarchy Form**
Please fill out Hierarchy form and include up line or down line as applicable
☐**W-9**

☐**Assignment of Commissions Form**

Complete this form if you will be assigning your commissions to your agency
☐**ACH Form**

Complete this form if you would like Direct Deposit, if not you will be mailed a check
☐**Agent Application**

All 3 pages filled out in their entirety
☐**HealthSpring Release Authorization and Fair Credit Reporting Act Disclosure**

This form gives us permission to perform your background check
☐**Sales Representative Addendum**

☐**Agent Acknowledgement & P&P Sign off Form**

Please attach:

☐Copy of current State Life & Health License(s)
☐Copy of voided check

Once you complete your contract please
Fax to: 888-519-7137
or
Mail it to:
P.O. Box 22750
Hot Springs, AR 71903
Or just use the included postage paid envelope
IF YOU HAVE ANY QUESTIONS PLEASE CALL
THE ELDERCARE MARKETING TEAM AT
800-777-9322

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Contact information

All information is required to complete contracting

Last Name, first name, middle initial | Date of Birth | Social Security Number

Address | City | State | Zip Code

Business Phone | Cell Phone | Fax Number | E-mail Address

Please list all websites and/or website affiliations:

Provider business office locations for last five years:

Ex: 10/12

Business address | City | State | ZIP Code | From | To

Business address | City | State | ZIP Code | From | To

Business address | City | State | ZIP Code | From | To

Professional designation:

Ex: 10/12

Type of professional designation | From | To

Type of professional designation | From | To

Type of professional designation | From | To

List any insurance agency affiliations for the past five years:

Name of agency | City where agency is located | From | To

Name of agency | City where agency is located | From | To

Please indicate the service area(s) in which you plan to sell HealthSpring (please select all that apply):
(You MUST have a currently active state Health license in all of the states for the service areas you selected below)

- ☐ Alabama
- ☐ Arizona
- ☐ Arkansas
- ☐ Delaware
- ☐ District Of Columbia
- ☐ Florida
- ☐ Florida
- ☐ Georgia
- ☐ Illinois
- ☐ Maryland
- ☐ Mississippi
- ☐ New Jersey
- ☐ Tennessee
- ☐ Texas
- ☐ West Virginia

Additional information:

If an answer to any of the following questions is "yes," attach details on separate sheet of paper.

	Yes	No
A. Has your license to sell insurance or HMO Products ever been denied, suspended or revoked by any state?	☐	☐
B. Have any complaints been filed against you with the State Department of Insurance or any other insurance regulatory board or agency within the last five years?	☐	☐
C. Have you ever been denied appointment or renewal appointment by any insurance and/or managed care company?	☐	☐
D. Have you ever been party to a lawsuit relating to the insurance or managed care industry?	☐	☐
1. Have any settlements ever been made on your behalf?	☐	☐
2. Are there any claims or cases presently filed or pending against you?	☐	☐
E. Have you ever filed for bankruptcy?	☐	☐
F. Have you ever been convicted or are you currently being charged or under investigation for any violation of the law other than minor traffic violations?	☐	☐
G. Are any legal actions pending against you by any employer, client, former associate, partner, state board of insurance, law enforcement agency or professional group or organization?	☐	☐
H. How long have you sold individual and/or group HMO products?	☐	☐
I. How long have you been in the insurance business?	☐	☐
J. Do you speak any foreign language? If yes, indicate language(s):	☐	☐

I certify that the above statements are true and complete and no misrepresentations are contained with the application or attachments.

Signature ✕ _____ *Date* _____

Active appointments with insurance and/or managed care companies:

Company Name _____ From _____ To _____

Company Name _____ From _____ To _____

Company Name _____ From _____ To _____

Company Name _____ From _____ To _____

Authorization and release:

I understand that HealthSpring Inc. will verify that the information in this application is correct and I hereby authorize HealthSpring Inc. or its representatives to contact and obtain information references in this application from an individual present or former client, insurer, corporation or other business entity, regulatory or licensing agency, or state, city or federal agency.

By applying for appointment with HealthSpring Inc., I extend absolute immunity to, and release and hold harmless from any and all liability: (i) HealthSpring Inc., its representatives, employees, trustees, directors, and officers; (ii) any individual, present or former client, insurer, corporation, or other business entity, regulatory or licensing agency, or state, city or federal agency providing information, their representatives, employees, trustees, directors and officers; (iii) any third party for any acts, communications, reports, records, statements, documents, recommendations or disclosures involving me, requested or received by HealthSpring Inc. and its representatives to, from, or by any third party, including otherwise privileged or confidential information.

I certify that the above statements are true and complete and no misrepresentations are contained within the application or attachments.

_____ ✖ _____ _____

Name (please print) *Signature* *Date*

Application for appointment includes:

- Completed application, with signature on authorization and release above
- Copy of Current State License(s)

Return completed application along with required documents to:

Corporate Contracting
Contracting.mailbox@healthspring.com
Fax: 410-537-8959
Attn: Corporate Sales Operations
3601 O'Donnell Street
Baltimore, MD 21224

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Agent Acknowledgement Form

&

Policy and Procedure Sign-Off

In the performance of my duties as a contracted Agent for HealthSpring, I hereby acknowledge the following:

1. In offering products to Medicare beneficiaries, an organization and its contracted brokers/agents may not engage in any of the following practices or activities. **Prohibited practices** include, but are not limited to, the following:
   - Discriminatory practices/Forgeries
   - Door–to-door solicitations
   - Misrepresentations or activities which would mislead, confuse, or misrepresent improper payment
   - Conducting outbound telemarketing in violation of CMS/HealthSpring policy
   - Unauthorized language interpretations
   - Distribution of incorrect enrollment materials
   - Enrollment and/or marketing at education events
   - Marketing in healthcare settings (i.e. waiting rooms, exam rooms, hospital patient rooms, dialysis centers, pharmacy counter areas)
   - Offering gifts or payments to induce enrollment
   - Accepting gifts or any commissions from affiliated providers, vendors, and customers
   - Distribution of disapproved or unapproved marketing materials
2. I will represent HealthSpring in a responsible, accurate, and respectable manner at all times.
3. I understand that the unsolicited contact of Medicare beneficiaries is prohibited. All appointments must be pre-scheduled, with consent and scope of appointment documented.
4. I will provide accurate information regarding eligibility requirements, plan benefits, grievance, appeals, and disenrollment procedures.
5. I will abide by all CMS, State, and HealthSpring marketing guidelines.
6. I will not discriminate against any Medicare beneficiary who is eligible for a HealthSpring offering.
7. I will not make any statement, claim, or promise that conflicts with, alters, or erroneously expands upon either the information contained within CMS-approved materials or HealthSpring materials.
8. I will not mislead, confuse, or misrepresent to potential members about HealthSpring, competitive plans, or Medicare.
9. I will not misrepresent myself as an agent of Medicare, Social Security, or any agency of the federal government.
10. I will not offer any form of enticement, such as gifts or payments, to induce enrollment by potential members.
11. I will identify myself as representing HealthSpring to all prospective or current members.
12. I understand that violation of any of the above will result in disciplinary action up to and including contract termination.

A copy of this form has been placed in my individual electronic file with HealthSpring and a copy can be furnished to me upon my request to the health plan.

By signing this, Acknowledgement Form I, _____ confirm that I have received HealthSpring corporate Sales policies and procedures and will abide by all of the requirements set forth above. I also attest that I have read them completely and thoroughly, understand them to the fullest extent, and agree to abide by the guidelines they establish. If at any time I am unclear about a policy or have a question I will consult my Sales Manager/Sales Lead for further guidance.

_____ _____

Employed/Contracted Agent Date

_____ _____

Sales Manager/Sales Lead Date

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Electronic Payment (ACH) Authorization Agreement

I hereby authorize _____ to deposit any amounts owed me by initiating credit entries to the bank account listed below in the amounts specified. Also, I authorize _____ the right to correct any Electronic Funds Transfer resulting from an erroneous overpayment by debiting my account for an amount not to exceed the original amount of the erroneous credit. This authorization is to remain in force until the company receives written notice from me of its termination in such time and in such manner as to afford the company a reasonable opportunity to act on it.

Vendor Information

Name (please print): _____

Social Security Number: ☐☐☐-☐☐-☐☐☐☐

OR

Tax ID Number: ☐☐-☐☐☐☐☐☐☐

Address: _____

_____

Deposit Information

Check One: ☐ Checking ☐ Savings Requested Start Date for ACH: _____

Check One: ☐ New ☐ Change ☐ Stop

Bank Routing # ☐☐☐☐☐☐☐☐☐ Bank Account # ☐☐☐☐☐☐☐☐☐☐☐☐

******MUST ATTACH A COPY OF A VOIDED CHECK******

Signature ✖ _____ Date _____

FINANCE USE ONLY	
RECEIVED:	**PS VENDOR #:**
ENTERED INTO PEOPLESOFT:	

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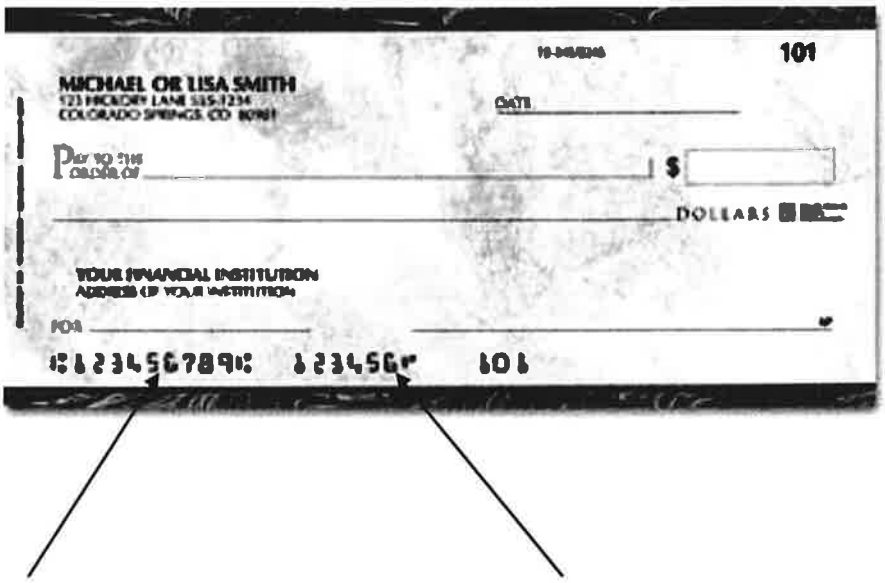
Electronic Payment (ACH) Authorization

Use this form to add, change or stop a direct deposit. All changes must be in writing. A full Electronic Payment (ACH) requires net pay to be deposited into one account.

To set up Electronic (ACH) payments, you must:

- Have the account currently set up at your bank
- Find out if the bank accepts electronic payments (ACH)
- Verify bank's routing number and your account number (See diagram below)
- Notify the bank that you are setting up Electronic Payment (ACH)
- Determine if the bank has special requirements
- For Savings, please attach a letter from your bank verifying the routing # and account #
- For checking, please attach a voided check or a letter from your bank



Routing Number

(9 Numeric Characters)

Account Number

(Up to 12 Numeric Characters)

SALES REPRESENTATIVE ADDENDUM
BROKER/AGENT

This Addendum is for a Subordinate Broker or Agent who is certified, licensed and appointed to sell Medicare Advantage products. Due to the high degree of compliance necessary and the fact that Medicare Advantage products are governed by State and Federal regulations, the Subordinate Broker or Agent need to comply with all HealthSpring Policies and Procedures, including but not limited to those set forth below.

Subordinate Broker or Agent agrees that it shall comply with all policies and regulations as set forth below.

Subordinate Broker or Agent agrees to sign the HealthSpring HIPAA Business Associate Agreement in the form provided by HealthSpring. HealthSpring will obtain signed copies of this documentation before authorizing the Contracted Agent to access, create or receive individually identifiable health information.

❑ **Agent Qualifications**

To be an authorized HealthSpring Agent/Broker, you must:

- Complete Agent/Broker credentialing administered by HealthSpring or its designee.
- Complete the HealthSpring Agent/Broker certification training and pass the required certification examination.
- Complete face-to-face training conducted by HealthSpring sales management in the market(s) where the Agent intends to sell.
- Be a licensed health agent in the state(s) in which HealthSpring operates, in good standing, and supply HealthSpring with a copy of the license upon request.
- Be appointed by HealthSpring as an agent, where applicable.
- Have an executed agreement with FMO, Subordinate SGA, MGA, GA or HealthSpring, as applicable.
- Agree to comply with all legal, compliance and regulatory guidance in accordance with applicable state, federal law and HealthSpring policies.
- Agree to receive continuing education relative to the current Medicare Advantage products and comply with any changes that occur relative to this program.
- Attend sales staff informational meetings in order to stay informed of compliance and regulatory changes, procedural changes, network changes, etc.
- Pass the annual recertification examination administered by HealthSpring or its designee.
- Agree to participate in field evaluations as required by CMS and HealthSpring.

- Have reasonable accessibility for receiving communications concerning immediate regulatory or network changes (i.e., phone, email, fax, pager, voicemail, etc.).

- Maintain a proficiency in, and knowledge of, HealthSpring's Medicare Advantage products as well as all necessary compliance requirements.

- Agree to adhere to HealthSpring sales performance and disciplinary standards as set forth in HealthSpring policies and procedures, herein incorporated by reference.

- Agree to comply with random drug testing programs in accordance with HealthSpring policy and procedure as applicable.

- Have an executed HIPAA Agreement for Agents affiliated with an Agency, or have a Business Associate Agreement for Agents directly contracted with HealthSpring.

❑ **Errors and Omissions**

Subordinate Broker or Agent shall, at all times during the term of this Agreement, maintain Errors and Omissions Insurance in amounts consistent with industry standards, but at no time less than $250,000 per occurrence and $250,000 aggregate limit, with a reasonable deductible. Subordinate Broker or Agent shall request that notice be provided to HealthSpring by the insurer of any reduction, modification, cancellation or termination thereof. Subordinate Broker or Agent shall provide evidence to HealthSpring that such coverage is in force prior to the execution hereof, and from time to time upon HealthSpring's request. Subordinate Broker or Agent shall notify HealthSpring immediately if such insurance is or will be reduced, modified, canceled or terminated.

❑ **Individual Leads**

HealthSpring is not responsible for supporting the Subordinate Broker or Agent with leads or financial support in their prospecting efforts. During a visit with the prospect, Subordinate Broker or Agent can present the HealthSpring Medicare Advantage products with full disclosure and enroll the prospect. Referrals may only be sought in accordance with HealthSpring policy and applicable CMS guidelines. Subordinate Broker or Agent must follow all guidelines and regulations that govern the proper procedure for prospecting, and selling, the HealthSpring product including all requirements set forth under MIPPA and the CMS Medicare Marketing Guidelines as amended from time to time.

❑ **Switching Hierarchies**

Subordinate Broker or Agent may change sales hierarchies upon six (6) months prior written notice to HealthSpring in accordance with such Agent or other entity's agreement with HealthSpring. Subordinate Broker or Agent are permitted to changes sales hierarchies no more than once per calendar year. In the event any piece of the sales hierarchy is terminated or ceases to exist for any reason whatsoever, those legal entities or Agents that are "downline" from such entity may change hierarchies upon at least ten (10) business days written notice to HealthSpring.

In addition, Subordinate Broker or Agent may change sales hierarchy at any time upon written mutual agreement with such Agent's or other entity's direct "upline" in the Hierarchy. Any HealthSpring business and commission payments associated with the Subordinate Broker or Agent will automatically move with such Agent to the new sales hierarchy they/it joins unless an assignment of commission has been executed and approved by HealthSpring.

❑ **Commissions – Individual Sales**

Enrollments must be a result of the direct contact between the Subordinate Broker or Agent and the individual prospect. HealthSpring will pay a commission for each individual whom Subordinate Broker or Agent enrolls in a HealthSpring Medicare Advantage Plan. Commissions are paid per the current commission schedule. The allocated portion of the commission payments will be paid directly to the Agent of Record during the normal commission payment schedule as set forth by HealthSpring policy unless otherwise agreed between the parties.

By:  _____

Print Name: _____

Date: _____

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Greetings from HealthSpring

Thank you for your interest in becoming a selling partner with HealthSpring and/or Bravo Health, a HealthSpring Company. Based in Nashville, Tennessee, HealthSpring got its start in 2000 and is now one of the country's largest and fastest-growing coordinated care plans whose primary focus is Medicare Advantage plans. HealthSpring currently owns and operates Medicare Advantage plans in Alabama, Arizona, Arkansas Delaware, Florida, Georgia, Illinois, Maryland, Mississippi, New Jersey, Pennsylvania, Tennessee, Texas, Arkansas and Washington, D.C. We are dedicated to improving the health of the communities we serve by delivering the highest quality and greatest value in healthcare benefits and services and look forward to welcoming you to our team.

What happens next?

Your first step in the on-boarding process will be to complete any necessary contracting paperwork. Please refer to the "Contracting Checklist" found in your contracting kit as a tool to help guide you through this process.

Upon completing contracting you will receive an email providing you instruction on how to access and complete the required AHIP exam. Because we greatly value our agents, we offer the AHIP exam at the discounted price of $100.00 when the exam is taken through our site http://healthspring.cmpsystem.com

Once you have passed AHIP, you will be directed to complete the following modules for 2013 certification: FWA, HIPAA, Selling with Integrity and Compliance training. Once all of these additional courses have been completed, please schedule your face-to-face training in your local market. This is the last step in your certification process as the training will then be processed by Corporate Sales Operations and you will receive a writing number and welcome email in the days after. Please make sure not to begin marketing our plans until you have received your welcome notification email or letter.

If you have any questions or need assistance in any part of the on-boarding process, please do not hesitate to contact Sales Operations by way of the contracting mailbox at contracting.mailbox@healthspring.com, and we will be happy to assist you.

Good luck in completing this process and we look forward to welcoming you to our team.

Thank you!

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Hierarchy Form

Agent Name _____

GA Name _____

MGA Name _____

SGA Name _____

FMO Name _____

Please check ONE

☐ Agent assigns commissions to an agency

☐ Agent paid directly by HealthSpring

Agent Signature _____

Date _____

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HealthSpring

RELEASE AUTHORIZATION AND FAIR CREDIT REPORTING ACT DISCLOSURE

The applicant for contracting acknowledges that this company may now, or at any time while contracted, verify information within the contract. In the event that information from the report is utilized in whole or in part in making an adverse decision, before making the adverse decision, we will provide to you a copy of the consumer report and a description in writing of your rights under the Fair Credit Reporting Act,15 U.S.C. § 1681 et seq.

Please be advised that we may also obtain an investigative consumer report including information as to your character, general reputation, personal characteristics, and mode of living. This information may be obtained by contacting your present and previous employers or references supplied by you. Please be advised that you have the right to request, in writing, within a reasonable time, that we make a complete and accurate disclosure of the nature and scope of the investigation requested.

Additional information concerning the Fair Credit Reporting Act, 15 U.S.C. § 1681 et seq., is available at the Federal Trade Commission's web site (http://www.ftc.gov).

By signing below, I hereby authorize all entities having information about me, including present and former employers, personal references, criminal justice agencies, departments of motor vehicles, schools, licensing agencies, and credit reporting agencies, to release such information to the company or any of its affiliates or carriers. I acknowledge and agree that this Release and Authorization shall remain valid and in effect during the term of my contract.

You may also be asked to adhere to a random drug test at which HealthSpring has the right to initiate, subject to state notification provisions.

For California*, Minnesota, and Oklahoma Applicants Only: *A consumer credit report will be obtained through Business Information Group, Inc., P.O. Box 541, Southampton, PA, 18966..*

*If an **investigative consumer report** and/or consumer report is processed, I understand that I am entitled to receive a copy. I have indicated below whether I would like a copy. Yes_____ No_____*

Initials Initials

*Date:*_____ *Signature of Applicant:* X_____

*Print Name:*_____

Para informacion en espanol, visite www.ftc.gov/credit o escribe a la FTC Consumer Center, Room 130-A 600 Pennsylvania Ave. N.W., Washington, D.C. 20580.

A Summary of Your Rights Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. ***For more information, including information about additional rights, go to www.ftc.gov/credit or write to: Consumer Response Center, Room 130-A, Federal Trade Commission, 600 Pennsylvania Ave. N.W., Washington, D.C. 20580.***

- ***You must be told if information in your file has been used against you.*** *Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment - or to take another adverse action against you - must tell you, and must give you the name, address, and phone number of the agency that provided the information.*
- ***You have the right to know what is in your file.*** *You may request and obtain all the information about you in the files of a consumer reporting agency (your "file disclosure"). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:*

    - *a person has taken adverse action against you because of information in your credit report;*
    - *you are the victim of identify theft and place a fraud alert in your file;*
    - *your file contains inaccurate information as a result of fraud;*
    - *you are on public assistance;*
    - *you are unemployed but expect to apply for employment within 60 days. In addition, by September 2005 all consumers will be entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.ftc.gov/credit for additional information.*

- ***You have the right to ask for a credit score.*** *Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.*
- ***You have the right to dispute incomplete or inaccurate information.*** *If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.ftc.gov/credit for an explanation of dispute procedures.*
- ***Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.*** *Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.*
- ***Consumer reporting agencies may not report outdated negative information.*** *In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.*
- ***Access to your file is limited.*** *A consumer reporting agency may provide information about you only to people with a valid need -- usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.*
- ***You must give your consent for reports to be provided to employers.*** *A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.ftc.gov/credit.*
- ***You may limit "prescreened" offers of credit and insurance you get based on information in your credit report.*** *Unsolicited "prescreened" offers for credit and insurance must include a toll-free phone number you can call if*

you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-5-OPTOUT (1-888-567-8688).

- ***You may seek damages from violators.*** *If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.*
- ***Identity theft victims and active duty military personnel have additional rights.*** *For more information, visit* www.ftc.gov/credit.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. Federal enforcers are:

Type of Business:	*Contact*
Consumer reporting agencies, creditors and others not listed below	*Federal Trade Commission: Consumer Response Center - FCRA* *Washington, DC 20580 1-877-382-4357*
National banks, federal branches/agencies of foreign banks (word "National" or initials "N.A." appear in or after bank's name)	*Office of the Comptroller of the Currency* *Compliance Management, Mail Stop 6-6* *Washington, DC 20219 800-613-6743*
Federal Reserve System member banks (except national banks, and federal branches/agencies of foreign banks)	*Federal Reserve Board* *Division of Consumer & Community Affairs* *Washington, DC 20551 202-452-3693*
Savings associations and federally chartered savings banks (word "Federal" or initials "F.S.B." appear in federal institution's name)	*Office of Thrift Supervision* *Consumer Complaints* *Washington, DC 20552 800-842-6929*
Federal credit unions (words "Federal Credit Union" appear in institution's name)	*National Credit Union Administration* *1775 Duke Street* *Alexandria, VA 22314 703-519-4600*
State-chartered banks that are not members of the Federal Reserve System	*Federal Deposit Insurance Corporation* *Consumer Response Center, 2345 Grand Avenue, Suite 100* *Kansas City, Missouri 64108-2638 1-877-275-3342*
Air, surface, or rail common carriers regulated by former Civil Aeronautics Board or Interstate Commerce Commission	*Department of Transportation ,Office of Financial Management* *Washington, DC 20590 202-366-1306*
Activities subject to the Packers and Stockyards Act, 1921	*Department of Agriculture* *Office of Deputy Administrator - GIPSA* *Washington, DC 20250 202-720-7051*

Form **W-9**
(Rev. September 2007)
Department of the Treasury
Internal Revenue Service

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 (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership
☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ _____
☐ Other (see instructions) ▶

☐ Exempt payee

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. The TIN provided must match the name given on Line 1 to avoid backup withholding. 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 3. 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 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

or

Employer identification number

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. citizen or other U.S. person (defined below).

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 4.

Sign Here **Signature of U.S. person** ▶  **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain 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 provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

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.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

DON'T FORGET YOUR LICENSE!!

Please attach a copy of any resident or non-resident license in which you would like appointed

NOTE: IF LICENSING A CORPORATION, PLEASE INCLUDE BOTH INDIVIDUAL & CORPORATION LICENSES

Eldercare pays all RESIDENT licensing fees!!!