# SUB-AGENT CONTRACT AGREEMENT

Form SACA 07/08

## JOINING THE EQUITABLE TEAM

**With Equitable Life & Casualty Insurance Company contracting as a Sub-Agent is easy. Simply follow the directions as outlined below and submit your completed information and documents to Equitable's Agency Department.**

**DIRECTIONS:**

**WARNING! In this agreement, pay special attention to all/any areas marked in red. The red indicates all/any areas that MUST BE completed by you.**

1. Complete all forms in this Sub-Agent Contract Agreement Packet. PLEASE NOTE: Contracts requiring the signature of a GA as the supervising agent must be included.

2. Prepare a copy of your current resident Life and Accident & Health license and submit it with your Sub-Agent Contract Agreement.

3. If your state requires a CONTINUING EDUCATION CERTIFICATE OF COMPLETION for Long Term Care, please submit a copy of this certificate with your Sub-Agent Contract Agreement.

4. Include a check for your appointment fee made payable to Equitable. Contact the Agency Department at 1-800-352-5121 for details regarding these fees. Equitable's Agency Department will submit an application for appointment for you with the state insurance department where required. If you prefer to pay by credit card, complete the Credit Card Authorization Form (page 10) included in this packet.

5. If you are allowing a Staff Member in your Agency to have access to protected personal information, please contact Agency regarding the Business Associate Agreement.

**Once you've completed each step above, send all of your information, INCLUDING COPIES OF YOUR COMMISSION SCHEDULES, to Equitable's Agency Department by fax, e-mail, or mail:**

**Fax:** 801-579-3781
**E-mail:** Send scanned paperwork to AgencyServices@EquiLife.com
**Mail:** Equitable Life & Casualty Insurance Company
ATTN: Agency Department
P.O. Box 2460
Salt Lake City, UT 84110-2460

**Questions? E-mail AgencyServices@EquiLife.com or call toll free 1-800-352-5121.**

# SUB- AGENT CONTRACT AGREEMENT

*Application must be completed in full. Please print legibly.*

**Date: (mm/dd/yyyy)** ☐☐-☐☐-☐☐☐☐

**Title:** ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Other ________

**Applicant Last Name:**

**Given Name: (First / Middle)**

**Birthdate: (mm/dd/yyyy)** ☐☐-☐☐-☐☐☐☐

**Preferred Name:**

**SS #*:** ☐☐☐-☐☐-☐☐☐☐

**Taxpayer ID #*:** ☐☐-☐☐☐☐☐☐☐

* Please Note: SS# and Taxpayer ID# must match IRS records exactly, or monetary penalties may be assessed

**Spouse Name:**

**Agency Name (dba):**

**Mailing Address:**

Street

City | State | Zip

**Shipping (UPS) Address▾:**

Street

City | State | Zip

▾ For Shipping (UPS) Address (please mark one): ☐ Commercial ☐ Residential

**Home Address:**

Street

City | State | Zip

**Business Phone:** (☐☐☐) ☐☐☐ - ☐☐☐☐ **Fax:** (☐☐☐) ☐☐☐ - ☐☐☐☐

**Cell Phone:** (☐☐☐) ☐☐☐ - ☐☐☐☐ **Home Phone:** (☐☐☐) ☐☐☐ - ☐☐☐☐

**E-mail:**

| | Yes | No |
|---|---|---|
| **1. Have you ever had your insurance license suspended or revoked?** | ☐ | ☐ |
| **2. Have you ever had disciplinary action taken against you by an insurance department?** | ☐ | ☐ |
| **3. Have you ever been refused E&O coverage?** | ☐ | ☐ |
| **4. Has an E&O company paid a claim for you?** | ☐ | ☐ |
| **5. Have you declared bankruptcy in the last seven years?** | ☐ | ☐ |
| **6. Have you been convicted of any felony or misdemeanor which involved the sale of insurance or which arose out of your business practices?** | ☐ | ☐ |
| **7. Are you a party in any litigation connected with the insurance business, or, are there any unsatisfied judgments outstanding against you arising out of the insurance business?** | ☐ | ☐ |
| **8. Do you have any unpaid debts with other insurers?** | ☐ | ☐ |

**If you answered "yes" to any of the above questions, please include a separate sheet with an explanation.**

**Products you are interested in marketing:** *(plan availability varies by state)*

- ☐ Medicare Supplement
- ☐ Short Stay Nursing Home
- ☐ Home Care
- ☐ Cancer Plan
- ☐ Long Term Care
- ☐ Senior Life
- ☐ Critical Illness
- ☐ Cash Supplement

## ACKNOWLEDGEMENT

I understand that as part of the Company's procedures for processing my application or evaluating me for contract and licensing purposes, an investigative report can be made where information can be obtained through personal interviews with third parties, such as family members, business associates, financial sources, friends, neighbors, or others with whom I'm acquainted. This inquiry includes information as to my character, business reputation and financial stability, whichever may be applicable. I have the right to make a written request within a reasonable period for a complete disclosure of information concerning the nature and scope of the investigation. My signature below operates to release from all liability and responsibility those parties supplying information to the Company and I authorize the Company to use this information where its legal interest and/or obligations are involved. Further, I acknowledge that I have no objection to the Company's investigating any of these facts and agree to indemnify and hold the Company harmless against any liability which may result in conducting such investigation.

The Company may also request a consumer credit report for contract and licensing purposes from a consumer credit reporting agency. If I wish the credit reporting agency to send me a free copy of both this consumer credit report and any investigative report sent to the Company I have checked the following box: ☐

I understand that this application will form a part of my contract with Equitable Life & Casualty and the information is accurate and true to the best of my knowledge. I further understand that if any material information given in this application is found to be incorrect or incomplete, it will be grounds for termination of my contract at the sole discretion of the Company. **New business applications may not be written until you have received notification that your contract has been approved and, if by law, your appointment is registered with the state insurance department.**

**Agent Signature:**________________________________________ **Date:** ________________________

## SUB-AGENT AGREEMENT

The undersigned agent hereby represents and warrants to Equitable Life & Casualty Insurance Company ("the Company") the following:

1. I, the undersigned, understand and hereby acknowledge that the Company does not compensate sub-agents; that once I am authorized to represent the Company, I can only place business for the Company through my General Agent (GA), known as_____________________________________________, for whom I am designated as sub-agent; that said GA alone will be accountable to me for my compensation in accordance with a contract or agreement that I have with said GA; and, that the GA is not authorized to and cannot bind or obligate the Company for my compensation or for the performance of any contract or agreement which said GA may have with me.
2. I will fully comply with all applicable insurance laws and regulations, and all laws and regulations relating to the sale of insurance in the state in which I do business, including those that relate to agent licensing.
3. I understand and hereby acknowledge that I have no authority or power to bind, obligate or create any liability against the Company through any act, omission to act or representation made, directly or indirectly, apparent or expressed and whether written or oral, except representations made in the Company's insurance policies or brochures.
4. I will submit to the Company, for approval, any form of advertising relating to their products and/or name prior to using it.
5. I will not induce, directly or indirectly, any policyowner to relinquish any policy with the Company, except where directly authorized to do so.
6. I will hold harmless and indemnify the Company from any and all actions, claims, liens, suits, or other matters that may arise against the Company as a result of any act or failure to act on my part.
7. I will conform to the Company's published regulations and directives now or hereafter promulgated.
8. I understand and agree that should I breach any of the foregoing, the Company, at its option, may terminate my right to sell its products and/or forfeit my renewal commissions after giving written notification of its option to my GA. For purposes of written notice from the Company to me, I hereby state and agree that notice sent to and received by my GA is sufficient and proper notification to me to the same extent as if personally received by me.
9. This agreement terminates and supersedes any and all prior agreements, or contracts, relating to solicitation of insurance between the parties. This agreement is not effective until dated and countersigned by an Officer of the Company.
10. The parties agree that the attached HIPAA Addendum is incorporated into and becomes a part of this Agreement. Notwithstanding anything herein to the contrary, the Company may unilaterally amend the HIPAA Addendum at its discretion to comply with regulatory or other requirements and will thereafter distribute a revised HIPAA Addendum to the Sub-Agent with an effective date for the revision.

**IN WITNESS WHEREOF**, the parties have executed this Agreement as of the Effective Date indicated below.

DATED this ___________ day of ________________, _________ [Leave blank. "Effective Date" to be assigned by the Company.]
Month Year

**Sub-Agent Signature:**____________________________________ **Date:** _________________________________

**General Agent Signature:** _________________________________ **Date:** _________________________________

***Approved By:*** ___________________________________________ Date: _________________________________
Authorized Company Officer

___________________________________________ Date: _________________________________
Authorized Agency Representative

## BACKGROUND INVESTIGATION CONSENT

I, ______________________________________________, hereby authorize Equitable Life & Casualty and/or its agents to make an independent investigation of my background, references, character, past employment, education, credit history, criminal or police records, including those maintained by both public and private organizations and all public records for the purpose of confirming the information contained on my Application and/or obtaining other information which may be material to my qualifications for contracting now and, if applicable, during the tenure of my appointment with Equitable Life & Casualty.

I release Equitable Life & Casualty and/or its agents and any persons or entity, which provides information pursuant to this authorization form, any and all liabilities, claims or lawsuits in regard to the information obtained from any and all of the above referenced sources used.

As part of the background investigation referenced above I understand that Equitable Life & Casualty utilizes the services of Debit-Check.com to investigate if a debit balance exists with any other insurance company with whom I have or have had a contract and/or appointment. I understand the information compiled by Debit-Check.com comes from companies that subscribe to their service, and those companies are solely responsible for the accuracy of the information provided. I further understand that data supplied to Debit-Check.com is added or deleted on an ongoing basis and is accurate only as of the specific date and time processed. In association with the background investigation referenced above I hereby authorize Equitable Life & Casualty to proceed with a Debit-Check.com search.

The following is my true and complete legal name and all information contained herein is true and correct to the best of my knowledge:

______________________________
**Agent Signature**

______________________________
**Date**

__________ - __________ - __________
**Social Security Number***

______________________________
**Date of Birth***

*NOTE: The above information is required for identification purposes only, and is in no manner used as qualifications for employment. Equitable Life & Casualty is an Equal Opportunity Employer, and does not discriminate on the basis of Sex, Race, Religion, Age (40 and over), Handicap or National Origin.

**CREDIT CARD AUTHORIZATION FORM**
***FOR PAYMENT OF APPOINTMENT FEES****

**Today's Date:**

______________________________

**Type Of Card:** ☐ Visa ☐ MasterCard

**Card Number:**

______________________________

**Expiration Date:**

______________________________

**Card Holder Name As Shown Exactly On Card:**

______________________________

**Card Holder Billing Address:**

______________________________

**Appointment Fee Amount To Be Charged:**

______________________________

As a convenience to me, I hereby request and authorize you to pay and charge to my credit card for the amount listed above. This shall be payable to Equitable Life & Casualty Insurance Company provided there are sufficient funds in my account. I agree that your rights in respect to this charge shall be the same as if it were a check drawn and signed by me. I also agree to contact Equitable Life & Casualty Insurance Company of there are any changes to my credit card account information. I further agree that if any such charge be dishonored, you shall be under no liability.

**Agent Signature:**______________________________ **Date:** ____________________

*** You may remit fee with a check made payable to Equitable if you prefer.**

**HIPAA Business Associate Agreement (“HIPAA Addendum”)**

Pursuant to established guidelines, Equitable Life & Casualty Insurance Company (“Equitable” or “Company”) adheres to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and the privacy regulations promulgated under it. The Company has dedicated its resources to ensure compliance as a “covered entity” under HIPAA by designating a Director and Officer of the Company as its Privacy Officer, whose responsibilities range from Company compliance operations to periodic reporting to the Board of Directors; and,

Pursuant to established guidelines, the Company continues to adhere to the requirements of the Gramm-Leach-Bliley Act (GLBA) and the regulations promulgated under it. Customers of the Company receive an annual notice of Equitable’s privacy policy, while new customers are advised of the Company’s privacy policy upon their disclosure of protected information. Both established and new Equitable customers retain the right to either “opt-in” or “opt-out” of Company communications or affiliated product offerings, consistent with state prerequisites. Therefore, in accordance with this Addendum:

WHEREAS, a change in Equitable’s continued policy of protecting the privacy rights of our customers is mandated under federal law, now requiring Equitable to create and maintain a written privacy policy under the guidance of a Privacy Officer;

AND WHEREAS, it is Equitable’s commitment that such a privacy policy be one which is dedicated to preserving each customer’s right of privacy in the non-public personal and protected health information authorized to be collected and used by us;

AND WHEREAS, federal laws, namely HIPAA and GLBA, along with certain state laws, and the regulations adopted to implement those laws, require the formal establishment of a “privacy policy” with safeguards that protect against unauthorized disclosure of protected customer information;

AND WHEREAS, consistent with Equitable’s commitment to the protection of a customer’s, personal, financial and health information within the Company’s possession is the federal mandate that a Business Associate adhere to the established privacy policy of the Company when dealing with Equitable customers;

AND WHEREAS, federal law deems our contracted agents to be Business Associates of Equitable under our privacy policy;

THEREFORE, in consideration of your continued representation of Equitable under your Agreement with the Company, and further as a Business Associate of the Company, IT IS AGREED AND UNDERSTOOD AS FOLLOWS:

1. As a Business Associate of Equitable you agree to comply with the terms and conditions of the established privacy policy of the Company when dealing with an Equitable customer. For purposes of this Addendum, an “Equitable customer” includes a policyowner, past or present, including an insured spouse of a policyowner, or any person who provides to you that person’s non-public personal or health information protected under state or federal law and which is intended for disclosure to the Company.

2. As a Business Associate of Equitable you agree to protect and safeguard the non-public protected personal and health information of an Equitable customer from unauthorized disclosure to any other person, entity or organization unless authorized by the customer or by law.

3. As a Business Associate of Equitable you agree that any protected personal or health information of an Equitable customer within your possession is prohibited from use by you or any other person, entity or

organization, directly or indirectly, for marketing purposes unless so authorized in writing by the customer.

4. A violation by you of this agreement may result in disciplinary action against you,including but not limited to termination of your Agreement to represent Equitable and, at the option of the Company upon written notice to you, making your commission compensation non-payable to you; additionally, you may be subject to federal penalties upon your violation of the Company's privacy policy.

5. Equitable is not liable in any way for your violation of the Company's privacy policy, and you agree to hold the Company harmless in any action taken against the Company based upon your violation of Equitable's privacy policy or HIPAA privacy regulations, including reimbursement to the Company for attorney fees and costs attendant with Equitable's defense costs.

6. This Addendum is effective with the date of your Agreement and shall be a part of your Agreement with the Company and shall survive and be in effect upon termination of your Agreement.

Equitable Life & Casualty Insurance Company • 3 Triad Center • Salt Lake City • Utah 84180-1200
1-800-352-5121 • Fax: 1-801-579-3781 • E-mail: Agency Services@EquiLife.com • Website: www.EquiLine.com