CROWE & ASSOCIATES

CONTRACTING WITH CROWE

Welcome to Crowe & Associates!

To get started, please fill out the forms included with this cover page and fax, or send using a secure email, back to us with these additional documents:

- Copy of your insurance license
- Copy of your E&O (if you carry it)
- Copy of a voided check for direct deposit
- Copy of proof of anti-money laundering training
- Copy of written explanation for any background issues (outlined on the Background Information page)
- Copy of CE training certificate (if required in your state)
- If applying as principal of a corporation, please provide a corporate license and voided check in addition to your individual license.
- If applying for Athene and are a corporation, please provide corporate resolution, or list of authorized signers
- Please be advised that some carriers charge resident and-or non-resident appointment fees. Contact Crowe & Associates for details.

If you have any questions, please call **1 (203) 796-5403** for assistance.

We look Forward to Partnering with you!

Crowe & Associates

CONTRACT APPLICATION

Agent Name: _____ SSN: ____ - ____ - _____

Agency Name (if applicable): _____ Tax ID: ____ - _____

Personal Name or Principal: _____

Insurance License Number: _____ Birth Date (MM/DD/YYYY) ____/____/_____

NPN Number: _____ ☐ Male ☐ Female

Agent Home Address: _____

City: _____ State: _____ ZIP: _____ County: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____ County: _____

UPS Street Address: _____

City: _____ State: _____ ZIP: _____ County: _____

Phone Res: _____ Business: _____

Fax: _____ Mobile: _____

Email Address: _____

Previous Address in the last 10 years: _____

City: _____ State: _____ ZIP: _____ County: _____

By signing this form, I acknowledge that all information is true and correct to the best of my knowledge. I agree to receive all carrier required emails, and Crowe & Associates Compliance updates.

☐ ***Additionally, by checking here, I agree to let Crowe & Associates send me carriers, products, and lead opportunities.***

Preferred Method of Contact (can select multiple methods): ☐ Email ☐ Phone ☐ Text

_____ _____

INITIALS **DATE**

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BACKGROUND INFORMATION

All "Yes" Answers Must Have an Explanation to be Processed

Is there any indebtedness to any insurance company? If yes, provide the name of the company, amount, and the repayment agreement: ☐ Yes ☐ No

Have you ever been convicted of a felony or misdemeanor other than a traffic offense? If yes, explain and provide the date(s) of each: ☐ Yes ☐ No

Have you had your driver's license revoked? If yes, explain and provide date(s): ☐ Yes ☐ No

Are you in the process of, or have you ever, filed for bankruptcy? If yes, explain and answer the following questions: ☐ Yes ☐ No

- Have you ever filed bankruptcy, have been declared bankrupt or insolvent, or have had your salary garnished? ☐ Yes ☐ No
- Have you, or any business of which you were presently are a principal, been involved in a bankruptcy action, or compromised liabilities with creditors? ☐ Yes ☐ No
- Have you ever filed a petition for bankruptcy or for protection from creditors? ☐ Yes ☐ No
- Has any insurance or securities brokerage firm, with whom you have been associated, ever filed a bankruptcy petition or been declared bankrupt (either during your association or within 5 years after termination of such association)? ☐ Yes ☐ No
  - When was bankruptcy filed (MM/DD/YYYY)? ____ / ____ / _____
  - What was the amount of your bankruptcy? _____
  - Please select which you filed: ☐ Chapter 7 ☐ Chapter 11 ☐ Chapter 13
  - Please provide the date you filed for bankruptcy (MM/DD/YYYY): ____ / ____ / _____
  - Please provide the date your bankruptcy was paid off, (if applicable) (MM/DD/YYYY): ____ / ____ / _____
- Are you now, or have you ever been, employed by, or associated with to any degree, directly or indirectly, a bank, savings and loan, or other financial institution? ☐ Yes ☐ No
- Are you now subject of any complaint, investigation, or proceeding which could result in a yes answer to any of the preceding questions? ☐ Yes ☐ No

_____ _____

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Have you ever been refused a bond or Errors and Omissions Insurance? If yes, please explain: ☐ Yes ☐ No

Have you ever had your insurance license suspended or revoked? If yes, please explain: ☐ Yes ☐ No

Have you ever had disciplinary action taken against you with any Department of Insurance? If yes, please explain: ☐ Yes ☐ No

Are you, or at this present time, or have you been within the past five years, involved in any civil litigation, judgments, liens, or foreclosures? If yes, please explain: ☐ Yes ☐ No

Have you ever been denied an appointment with any insurance company? If yes, please explain: ☐ Yes ☐ No

Have you ever been terminated for cause by any insurance carrier? If yes, please explain: ☐ Yes ☐ No

BANKING INFORMATION

Bank Routing Number (9 digits): _____ Account Number: _____

Branch Name or Location: _____

*BE SURE TO ATTACH A **VOIDED CHECK**

OTHER INFORMATION

Requesting Commission Advancing? ☐ Yes ☐ No

List a Beneficiary: _____ Relationship: _____

Resident Driver's License State: _____ Driver's License Number: _____

Have you taken out an AML (Anti-Money Laundering) course within the past two years? ☐ Yes ☐ No

If yes, provide the date of the AML (Anti-Money Laundering):

Date (MM/YYYY): ____ / _____ Course Name: _____

Where were you born? (City,State) _____

LONG-TERM CARE PARTNERSHIP CERTIFICATION: Please Attach Certificate or CE Update

I confirm that all information is true and correct, and I have given Crowe & Associates my permission to enter the information on my behalf.

_____ _____

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ADDITIONAL INFORMATION (SELECTHEALTH)

IF NOT SELECTING SELECTHEALTH AS A CARRIER, PLEASE DISREGARD THIS PAGE

PROFESSIONAL INFORMATION

Nevada Accident and Health Insurance License Number: _____

Issue Date (MM/DD/YYYY): ____ / ____ / ____ Expiration Date (MM/DD/YYYY): ____ / ____ / ____

Please list the names of the carriers with which you are currently appointed, or applying for appointment:

Have you ever been cited, fined, suspended, revoked, or refused a license by any state? ☐ Yes ☐ No

If yes, provide the state, month, and year: State: _____ Date (MM/YYYY): ____ / _____

Have you previously been appointed with SelectHealth? ☐ Yes ☐ No

Please list any languages, other than English, that you speak fluently: _____

PROFESSIONAL REFERENCES

List any professional associations to which you belong:

Name of Organization: _____ Member Since (MM/DD/YYYY): ____ / ____ / _____

Name of Organization: _____ Member Since (MM/DD/YYYY): ____ / ____ / _____

List two professional references that can attest to your honesty, professionalism, and ethical standards of practice:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

DISCIPLINARY ACTIONS

Have you ever been excluded from participating in a government healthcare program such as Medicaid or Medicare? ☐ Yes ☐ No

If yes, please provide complete background and detail of circumstances, paying particular attention to activities affecting interstate commerce, (if needed, you may attach another page):

By signing this form, I acknowledge that all information is true and correct to the best of my knowledge.

_____ _____

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LETTER OF EXPLANATION

Date of Action (MM/DD/YYYY): ____ / ____ / _____

Action: _____

Reason: _____

Explanation:

Date of Action (MM/DD/YYYY): ____ / ____ / _____

Action: _____

Reason: _____

Explanation:

Date of Action (MM/DD/YYYY): ____ / ____ / _____

Action: _____

Reason: _____

Explanation:

USE ADDITIONAL PAPER IF NECESSARY

LICENSES

AML Provider: ☐ Limra ☐ None ☐ Other Date Completed (MM/DD/YYYY): ____ / ____ / _____

If other, please provide certificate of completion.

Are you a Registered Rep with FINRA? ☐ Yes ☐ No

If yes, Broker/Dealer Name: _____ CRD#: _____

_____ _____

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Crowe & Associates

AGENT REFERRAL INFORMATION

Agent Name: _____ Phone: _____ Relationship: _____

Agent Name: _____ Phone: _____ Relationship: _____

Agent Name: _____ Phone: _____ Relationship: _____

Agent Name: _____ Phone: _____ Relationship: _____

Agent Name: _____ Phone: _____ Relationship: _____

Agent Name: _____ Phone: _____ Relationship: _____

Agent Name: _____ Phone: _____ Relationship: _____

Agent Name: _____ Phone: _____ Relationship: _____

Agent Name: _____ Phone: _____ Relationship: _____

Agent Name: _____ Phone: _____ Relationship: _____

Agent Name: _____ Phone: _____ Relationship: _____

Agent Name: _____ Phone: _____ Relationship: _____

YOU CAN EARN EXTRA MONEY

CALL YOUR SALES DIRECTOR FOR MORE DETAILS ON OUR REFERRAL PROGRAM!

304 FEDERAL RD, STE 107 | BROOKFIELD, CT 06804 | 1 (203) 796-5403 | www.croweandassociates.com

_____ _____

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REPLACE THIS PAGE WITH A COPY OF YOUR E&O INSURANCE CERTIFICATE OF COVERAGE

IMPORTANT: E&O Certificate must list your full name as the insured.

Please use the following examples as reference:

CORRECT:

Name of Insurance Agency
Full Agent Name
Address Line 1
Address Line 2
City, State, ZIP

INCORRECT:

Name of Insurance Agency
Address Line 1
Address Line 2
City, State, ZIP

If an individual's name is not listed correctly, please provide a letter from the E&O Carrier listing agents covered under agency policy.

Crowe & Associates

SIGNATURE

GENERAL AGENT: Crowe & Associates

I, _____, hereby authorize Crowe & Associates to affix or append a facsimile of my signature, as set forth below, to all required signature fields on all Insurance Carrier documents through the software or through any other means, including without limitation, by e-mail or orally. For which I have authorized Crowe & Associates to submit all such forms and agreements on my behalf, for the purposes of being Contracted to sell products of Carriers through Crowe & Associates. I hereby release, indemnify and hold harmless Crowe & Associates against any and all claims, demands, losses, damages, and causes of action, including: expenses, costs and reasonable attorneys' fees, which they may sustain or incur as a result of carrying out the authority granted hereunder.

I affirm that the information I have submitted through the interview process to Crowe & Associates is correct to the best of my knowledge and acknowledge that I have read and reviewed the documents for which I am authorizing my signature to be affixed to. I acknowledge and agree to indemnify and hold harmless any third party from and against any and all claims, demands, losses, damages, and causes of action, including: expenses, costs and reasonable attorneys' fees, which such third party may incur as a result of its reliance and acceptance on any form or agreement of a facsimile of my signature.

By signing this form, I acknowledge that all information is true and correct to the best of my knowledge.

Please read, sign, and send back.
Additionally, please sign in the center of the box below:

EXAMPLE:

ALL PAGES MUST BE SIGNED

Crowe & Associates

Check the box next to the Carrier names that you would like to select. For non-resident state requests, please write in state next to the carrier. Please be advised that some carriers charge resident and-or non-resident appointment fees. If you are requesting non-resident appointment, please indicate what states in the block provided.

CARRIERS	✓	NON-RES STATES
Aetna Medicare Advantage/ Coventry **LINK**		
Aetna Medicare Supplement (ACI/ CLI)		
AGLA Life with Living Benefits		
Alignment Health **LINK**		
American Equity		
American General Life Brokerage Annuity		
Americo		
Americo Legacy		
Anthem BCBS/ Empire/ Amerigroup/ Caremore **LINK**		
Assurity Legacy		
Athene Annuity & Life Assurance Company		
Athene, IA Annuity		
Baltimore Life		
Banker's Fidelity Life/ Assurance Company		
BayCare **LINK**		
Blue Cross Blue Shield MI **LINK**		
Bright ACA **LINK**		
Brighthouse Financial		
Capitol Life - Med Supp **LINK**		
Cigna ACA **LINK**		
Cigna Final Expense/ Med Sup (Arlic/ Loyal American/ CHLIC)		
Cigna HealthSpring (Bravo Health) **LINK**		
Clover Health **LINK**		
Columbian Mutual Life Insurance Company		
Combined Insurance Company of America		
Devoted **LINK**		
Emblem/ Connecticare **LINK**		
Equitable Annuity		
Equitrust		
F&G		
F&G (Legacy)		
Foresters Financial		
Foresters Life		
Freedom/ Optimum **LINK**		
Global Atlantic		
Great American		
Great Western GI Life		
Guarantee Trust Life		
HealthFirst **LINK**		

CARRIERS	✓	NON-RES STATES
Humana **LINK**		
Independence Blue Cross		
John Hancock		
Lincoln Financial		
LUMICO MS **LINK**		
Medico Group		
Molina ACA **LINK**		
Molina MA **LINK**		
Mutual of Omaha Med Supp/ PDP		
Mutual of Omaha Insurance Company (Omaha Insurance, United of Omaha Life Ins., United World Life Ins.)		
National Care Dental **LINK**		
National Guardian Life		
National Guardian Life Med Supp **LINK**		
National Life Group **LINK**		
National Western		
Nationwide		
North American Company (NACOLAH) Life & Annuity		
Oceanview		
Oscar Health **LINK**		
Protective Life		
Prudential		
Regence		
Royal Neighbors of America		
SCAN		
SelectHealth **LINK**		
Sentinel Security Life Insurance Company		
Simply **LINK**		
Sons of Norway **LINK**		
The Standard		
Transamerica New York		
Transamerica Premier		
United Home Life **LINK**		
United Security Assurance		
UnitedHealthcare **LINK**		
USIC MS **LINK**		
Washington National		
WellCare **LINK**		
William Penn		
Other:		

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AGENT AGREEMENT

Crowe & Associates Free Medicare Lead Program Agent Agreement

- The program reimburses 100% of costs up to $500/month for Medicare leads, marketing, or advertising costs for the first 6 months of participation in the program.
- After 6 months, reimbursement will be 50% up to $500/month.
    - Example: $1,000 of expenses submitted would pay a $500 reimbursement for the month.
- The 100% reimbursement will start when the first reimbursement is submitted and reduce to 50% in 6 months.
- Reimbursement will reduce to 50% after 3 months if 6 applications (Medicare Advantage or Medicare supplement) have not been submitted in that time.
- A minimum of 5 sales per month (Medicare Advantage or Medicare Supplement) will be required to continue being reimbursed at the 50% level. Continued participation will be determined on a case by case basis.
- Release requests will not be honored until 6 months after an agent's last reimbursement.
- Agents will receive full street commission. New and renewal commissions will not be reduced while participating in the lead program. Agents will continue to own their individual books of business.
- Agents will only be reimbursed for one type of expense per month. Receipts for more than one type of expense will not be accepted.
- Receipts of expenses must reflect the expense was exclusive to Medicare, show that has been paid and be submitted to our office within 30 days of the transaction, (email to **lisa@croweandassociates.com**).
- **Crowe & Associates must be the upline for all active Medicare companies. There will be no exceptions.**
- Agent does not need to have other lines of business with Crowe & Associates to participate.
- Agents may only enter one submission per calendar month.
- Receipts cannot be altered or have information redacted in any fashion.
- Gift card or client referral gift receipts are not reimbursable.

Agent Name: _____

Agent Signature: _____

Date: _____

**Crowe & Associates reserves the right to change or alter program requirements at any time.*

_____ _____

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