HEALTH PLAN ADMINISTRATORS, INC.
RX COPAY CARD SOLICITOR INFORMATION FORM

Print Name _____ Date of Birth _____ Social Security# _____
Corporation/Agency Name _____ Tax I.D. * _____ E-Mail _____
Business Street Address _____ City _____ St. _____ Zip _____
Resident Street Address _____ City _____ St. _____ Zip _____
Business Telephone # (_____) _____ Fax # (_____) _____ Resident Telephone # (_____) _____
UPS Delivery Address _____ City _____ St. _____ Zip _____
* If Commissions are to be paid to a Corporation, and you are not the Owner / Officer, we need an assignment of commissions signed by you. We must also have another Form completed by the Owner / Officer.

PLEASE ANSWER THE FOLLOWING QUESTIONS

1. Have you ever been convicted of a felony?_____*
2. Have you ever been involved in an investigation with any State Insurance Department?_____*
3. Has your license ever been suspended, cancelled or revoked by any State Insurance Department?_____*

* If Yes to any questions , 2 or 3, enclose complete details on a separate piece of paper, with your signature and date.

ASSIGNMENT OF COMMISSION REQUEST

Only complete the following if you want HPA to pay your commissions to someone else.

I _____ **HPA Code #** _____

hereby assign to **Assignee**:_____ all of my right, title, and interest in commissions and/or renewals to which I am now entitled or become entitled, under existing contracts and agreements, heretofore entered into by and between myself and Health Plan Administrators, Inc. I hereby authorize and empower Health Plan Administrators Inc., to pay assignee all commissions and renewals now due or which may accrue under said contracts, for a period of one year from this date and thereafter until such time as I terminate this assignment by written notice to Health Plan Administrators, Inc. I agree that such payments of commissions under my contract, the same as if payment was made directly to me. I hereby covenant and agree that I am the absolute and sole owner of said commissions, free from prior assignment or any encumbrance of any kind or character whatsoever, and that I have full right and lawful authority to sell and transfer the same as aforesaid.

Witness my hand this _____ day of _____, Year _____, Agent's Signature _____

CAUTION: The person assigning his or her commissions (assignor) will not recover the right to receive any further commissions during the one year period from the date of this assignment unless and until the person to whom such rights are assigned (assignee) releases, in writing, his or her rights to receive such commissions. Please be certain you understand this before signing the form. This instrument may be revoked, in writing, by the Assignor at any time after the one year period.

Address of Assignee: _____

Tax I.D.# _____ **Assignee's HPA Code #** _____

STATEMENT OF UNDERSTANDING & AGREEMENT FORM

Health Plan Administrators, Inc. (herein called HPA, Inc.) agrees to pay **15%** commissions on the Rx Co-Pay Plan, equal to the plan cost due and paid to HPA, Inc., the plan administratorin accordance with and subject to the conditions and covenants below.

- The term "Rx Card cost due and paid" shall mean monies, excluding any administrative and enrollment fees, due and paid for the Plan to HPA after the effective date of this Agreement by each card member and for whom the solicitor of record.
- This Agreement may be terminated by either party with a 30 days written notice but only with respect to new cases. Such terminations will have no effect on the payment of commissions on business written prior to the effective date of termination as may otherwise be payable.
- No advertising material bearing HPA or the Insurance Company's name or describing or naming a product administered by HPA will be printed without prior written approval of HPA.
- The solicitor is an independent contractor, not an employee of HPA. The solicitor has no authority to act on behalf of the Company, bind coverage, waive or alter any provision of the application or the Plan. Representations and opinions of the solicitor are not binding on the Company.

READ CAREFULLY BEFORE SIGNING

The above information is true and complete. I understand false statements on this form may be sufficient cause for termination. I have read the Agreement and understand that if these guidelines are not followed, the result will be termination of the Agreement. A photocopy of this authorization shall be considered as effective and valid as the original.

Siolicitor Signature _____ Date _____ Title _____
GA Name: Robert D. Fink and Associates _____ HPA Code #: 890900000 _____ E-mail bob@rdfinscenter.com
Address: _____ Tele: _____ Fax: _____
MGA Name: _____ HPA Code #: _____ E-mail: _____
Address: _____ Tele: _____ Fax: _____

Mail this completed form to your GA or MGA. If none is listed, fax it to 1-813-963-5570 or mail to:

HPA, INC. ~ 15436 N. FLORIDA AVE, SUITE 105 ~ TAMPA, FL 33613