Capital Health Plan

An Independent Licensee of the Blue Cross and Blue Shield Association

New Agent Appointment Instructions

Thank you for your interest in Capital Health Plan (CHP) and congratulations on taking the first step to becoming appointed? Below are some important steps to get started:

1. Capital Health Plan offers benefit plans for large and small employer groups, as well as benefits plans for individuals & families on the Federally-facilitated Marketplace. With the exception of the Individual Market Products, Capital Health Plan will not appoint an agent unless you have at least one employer group client assigned to your book of business. **You can write new business with CHP or you can submit an AOR on an existing account to meet this first requirement.** You can learn more information about our plans here: Agents / Capital Health Plan.

2. Second, you will need to complete the Agent Appointment Package and submit the information in full to CHP at agent@chp.org. Please note:

    a. If you are a new Agent joining an Agency that is already established with Capital Health Plan, you may not owe the $61.98 Agent Appointment Fee. Before paying this fee, please contact our office to verify. You may call (850-523-7333) or e-mail (agent@chp.org) for this information.

    b. If you are a new Agent that owes the $61.98 Agent Appointment Fee, please make sure you **DO NOT** submit this fee until you have submitted your Agent Appointment Package and it has been accepted by CHP. The appointment fee will need to be mailed to the following address within 10 days of your approved application:

Capital Health Plan
Agent Appointments
Sales & Account Management Department
P. O. Box 15349
Tallahassee, FL. 32317-5349

Thank you, again, for your interest in Capital Health Plan! We look forward to partnering with you and appreciate your support in promoting CHP's health care services to our community. Please feel free to contact our Sales & Account Management Department should you have any questions: 850-523-7333.

Sincerely,

Mark S. Hicks, Sr.
Director, Sales & Account Management

Appointment Application Checklist

Capital Health Plan will not accept incomplete Agent Appointment requests.

Please make sure you have included the following with your submission:

☐ **NEW OR EXISTING CLIENT ACQUISITION**

- ☐ EXISTING BUSINESS: ◯ Agent of Record Letter
- ☐ NEW BUSINESS: ◯ Employer Group ◯ Individual *(must provide FFM Certificate)*

☐ **AGENT CONDITIONS FOR APPOINTMENT**

☐ **LICENSE #(s) AND DESCRIPTION(S)**

☐ **IMPORTANT QUESTIONS**

☐ **EMPLOYMENT HISTORY**

☐ **AGENT ATTESTATION**

☐ **VENDOR INFORMATION PROFILE (ON AGENCY LETTERHEAD)**

***Current Agency (Vendor) Letter Must Include Lawson Vendor ID**

***New Agency (Vendor) Letter Must Include**

- ☐ **W-9**
- ☐ **ACH ENROLLMENT & AUTHORIZATION FORM**
- ☐ **VOIDED CHECK**

☐ **CHPCONNECT ONLINE REGISTRATION** *(to access commissions & renewals)*

☐ **CHPCONNECT USER AGREEMENT**

☐ **BUSINESS ASSOCIATE AGREEMENT**

☐ **AGENT APPOINTMENT FEE IF APPLICABLE** *($61.98)*

DATE MAILED: CK#

AGENT CONDITIONS FOR APPOINTMENT

Appointment Application

All information provided must match the information in the Office of Insurance Regulation (OIR) database.

Type of Market Applying to Represent: ☐ **Group** ☐ **Individual (FFM certificate required)**

AGENCY INFORMATION

Agency Name: _____

Agency Address: _____

City: _____ State: _____ Zip Code: _____

AGENT INFORMATION

Agent Name (*Last, First, Middle*): _____ Suffix: _____

Date of Birth (*mm/dd/yyyy*): _____ SSN: _____ Gender: ☐ M ☐ F

Home Address: _____ Telephone: (___) _____

City: _____ State: _____ Zip Code: _____

Correspondence Address: _____ Telephone: (___) _____

City: _____ State: _____ Zip Code: _____

Email Address: _____ Fax: (___) _____

Can Capital Health Plan (CHP) contact you by email regarding company, product, promotional, sales and bonus programs? ☐ YES ☐ NO

Are you currently a resident of the State of Florida? ☐ YES ☐ NO

Are you currently licensed in the State of Florida to sell health insurance products? ☐ YES ☐ NO
If you have a non-resident license to sell health insurance products in Florida, please select YES.

LICENSES #(s) AND DESCRIPTION(S):

A photocopy of the license(s) listed below must be included with this application.

Licenses #	Type of License	State	NPN #

The following questions are applicable to all Agents, Agencies, Corporations, Partnerships, and other business ventures, and to each of the partners, members, directors, officers, and agents individually. If "Yes" is used as any answer to the following questions, please provide a full account of the details on a separate sheet of paper and return to CHP with your application.

1. Have you (or the partners, members, directors, officers, or agents of this company/corporation/partnership) ever been convicted of a crime (whether felony or misdemeanor) other than a minor traffic violation?
   ☐ YES ☐ NO

2. Have you (or the partners, members, directors, officers, or agents of this company/corporation/partnership) ever been fined, reprimanded, sanctioned, or been the subject of a consent decree in any state for a violation of insurance laws, HMO regulations, or other administrative regulations?
   ☐ YES ☐ NO

3. Have you (or the partners, members, directors, officers, or agents of this company/corporation/partnership) ever been refused license to sell insurance/HMO products, or has a license to sell insurance/HMO products ever been suspended or revoked by any state?
   ☐ YES ☐ NO

4. Have you (or the partners, members, directors, officers, or agents of this company/corporation/partnership) ever been employed by an insurance/HMO company, or other organization providing for or assisting with the administration of health care or other employee benefits, where the employment contact was terminated or non-renewed because of allegations of wrongdoing?
   ☐ YES ☐ NO

5. Have you (or the partners, members, directors, officers, or agents of this company/corporation/partnership) ever surrendered any insurance or HMO license, whether voluntary or involuntary?
   ☐ YES ☐ NO

6. Have you (or the partners, members, directors, officers, or agents of this company/corporation/partnership) ever declared bankruptcy, had a lien placed against you or your company, been a judgment debtor, or had other problems with you or your company's credit history?
   ☐ YES ☐ NO

7. Are you (or the partners, members, directors, officers, or agents of this company/corporation/partnership) currently names party in any lawsuit?
   ☐ YES ☐ NO

8. Have you ever been short in accounts with any employer?
   ☐ YES ☐ NO

9. Has an application for bond ever been declined to you?
   ☐ YES ☐ NO

EMPLOYMENT HISTORY

Name of Present/Most Recent Employer: _____

Job Title/Position: _____ Supervisor: _____

Address: _____ Telephone: (___) _____

City: _____ State: _____ Zip Code: _____

Years of Service: _____ Years and _____ Months

PRIVACY AND SECURITY

For this subsection, "Appointed Agent" shall be referenced as "Business Associate."

1. Privacy and Security of Protected Health Information
    a. Permitted Uses and Disclosures. Except as otherwise permitted by CHP (hereafter referred to as "Company"), Business Associate may use, disclose, or request the minimum necessary Protected Health Information and Nonpublic Personal Financial Information to perform functions, activities, or services for, or on behalf of, Company as specified in this Agreement, provided that such use, disclosure, or request would not violate the HIPAA-AS Privacy Rule if done by Company.
    b. Prohibition on Unauthorized Use or Disclosure. Business Associate shall not use or disclose Protected Health Information or Nonpublic Personal Financial Information other than as permitted or required by Company or as required by law.
    c. Information Safeguards and Breach Reporting
        i. Privacy of Protected Health Information. Business Associate shall use appropriate safeguards to prevent use or disclosure of Protected Health Information and Nonpublic Personal Financial Information not provided for by Company.

            Business Associate shall report in writing to Company's Corporate Compliance Office any use or disclosure of Protected Health Information or Nonpublic Personal Financial Information not provided for by Company as soon as practicable but no later than five business days after Business Associate becomes aware of the unauthorized use or disclosure. Unless otherwise directed by Company's Corporate Compliance Office, Business Associate shall include in the report the following:
                1. The date of the unauthorized use or disclosure;
                2. The name and (of known) address of the person or entity that received Protected Health Information as a result of the unauthorized disclosure;
                3. A brief description of the Protected Health Information that was the subject of the unauthorized use or disclosure;
                4. A brief statement of the nature of the unauthorized use or disclosure;
                5. The name, date of birth, and contract number of the individuals(s) whose Protected Health Information was the subject of the unauthorized use or disclosure;
                6. The corrective action that the Business Associate has taken or will take to prevent further unauthorized uses or disclosures; and
                7. The steps that Business Associate has taken or will take to mitigate any known harmful effects of the unauthorized use or disclosure.
        ii. Security of Electronic Protected Health Information. Business Associate shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic Health Information.

Business Associate shall report in writing to Company's Corporate Compliance Office any successful Security Incident as soon as practicable but no later than five days after Business Associate shall report in writing any attempted but unsuccessful Security Incident of which Business Associate becomes aware. Business Associate shall comply with this Section on the effective date of appointment.

d. Mitigation. Business Associate shall mitigate to the extent practicable any harmful effect of which Business Associate is aware that is caused by any use or disclosure of Protected Health Information or Nonpublic Personal Financial Information not provided for by Company.
e. Agents and Subcontractors. Business Associate shall ensure that its agents and subcontractors to whom it provides Protected Health Information agree in writing to the same privacy and security restrictions and conditions that apply to Business Associate with respect to that information.
f. Business Associate Guidance. Business Associate shall comply with any policy, procedure, or guidance with respect to Business Associate's responsibilities under Sections E that Company may, from time to time, issue and communicate in writing to Business Associate.
g. Management of Protected Health Information
    i. Access. Business Associate shall, within seven days following Company's request, make available to Company for inspection and copying Protected Health Information about an individual that is in Business Associate's custody or control, so that Company may meet its access obligations under the HIPAA-AS Privacy Rule.
    ii. Amendment. Business Associate shall, within 14 days following the Company's request, amend or permit Company to amend any portion of Protected Health Information that is in Business Associate's custody or control so that Company may meet its amendment obligations under the HIPAA-AS Privacy Rule.
    iii. Disclosure Accounting. Business Associate shall record the information specified below ("disclosure information") for each disclosure of Protected Health Information that Business Associate makes, excluding disclosures identified in 45 CFR § 164.528(a)(1) including, but not limited to, disclosures for Treatment, Payment, and Health Care Operations and disclosures under a HIPAA-AS compliant authorization, and shall report the disclosure information in writing to the Company's Corporate Compliance Office at P.O. Box 15349, Tallahassee, Florida, 32317-5349, within five days of Business Associate making the accountable disclosure. Disclosure information shall include:
        1. The disclosure date;
        2. The name (if known) address of the person or entity to which Business Associate made the disclosure;
        3. A brief description of the Protected Health Information disclosed;
        4. A brief statement of the purpose of the disclosure;

5. The name and date of birth of the individual whose Protected Health Information was disclosed; and
6. That individual's contract number.

iv. Inspection of Internal Practices, Books, and Records. Business Associate shall make its internal practices, books, and records relating to its use and disclosure of Protected Health Information and its protection of the confidentiality, integrity, and availability of Electronic Protected Health Information available to Company and the U.S. Department of Health and Human Services ("HHS") as requested or required to determine Company's compliance with the HIPAA-AS Privacy Rule and Security Rule.

v. Breach of Privacy and Security Obligations

1. Termination. Company and Business Associate specifically acknowledge and agree that a bread of any term of the Privacy and Security subsection of the Conditions for Appointment (the "Subsection") shall be considered a breach of material term of the Conditions, and Company may terminate the Agent's appointment.
2. Obligations on termination
    a. Return or Destruction of Protected Health Information. On termination of the Agent's appointment, Business Associate shall, if feasible, return to Company or destroy all Protected Health Information in its custody or control in whatever form or medium, including all copies and all derivative data, compilations, and other works that allow identification of any individual who is a subject of the Protected Health Information. Business Associate shall identify to Company in writing any Protected Health Information that cannot feasibly be return to Company or destroyed, and explain why return or destruction is infeasible. Business Associate shall limit further use or disclosure of Protected Health Information to those purposes that make its return or destruction infeasible. Business Associate shall complete these obligations as promptly as possible, but not later than 30 days following the effective date of the termination of the Agent's appointment.
3. General Provisions for the Subsection
    a. Definitions. The terms "Electronic Protected Health Information" and "Protected Health Information" have meanings set out in 45 CFR § 160.103, except Protected Health Information shall be limited to that information created or received by Business Associate from or on behalf of the company. The term "Required by Law" has the meaning set out in 45 CFR § 164.103. The term "Security Incident" has the meaning set out in 45 CFR § 164.304. The terms "Health Care Operations," "Payment," and "Treatment" have the meanings

set out in 45 CFR § 164.501. For purposed of this Addendum, Protected Health Information encompasses Company's Electronic Protected Health Information. The term "Nonpublic Personal Financial Information" has the meaning set out in Fla. Admin Code § 4-128.002 except Nonpublic Personal Financial Information shall be limited to that information created or received by Business Associate from or on behalf of Company.

b. Amendment to the Subsection. The Subsection automatically shall amend on the compliance date of any final regulation or amendment to the final regulation promulgated by HHS or a Florida regulatory agency concerning the subject matter of the Subsection such that Business Associate's obligations remain in compliance with the final regulation or amendment to final regulation, unless Company or Business Associate elects to terminate Section E by giving the other party written notice of termination at last 90 days before the compliance date of the final regulation or amendment to final regulation.
c. No Third Party Beneficiaries. No party shall be deemed a third party beneficiary of the Subsection.

GOOD STANDING CRITERIA

For an Appointed Agent to remain in good standing with the Company and maintain his or her Appointment as an Appointed Agent for Company, an Appointed Agent must:

1. Comply with the Conditions for Appointment.
2. Comply with all Capital Health Plan corporate policies and procedures.
3. Have a valid Florida health Agent license.
4. Provide evidence that all continuing education credits/coursework requirements have been and continue to be met (including all annual CMS required training) when requested by Company.

COMMISSIONS

Capital Health Plan shall pay Agents a commission for new sales and renewals, based on the corporate commission schedule and formulas in effect at the time of payment. Agent agrees to accept commission payment by Automated Clearing House (ACH).

PAYMENT FOR AGENT APPOINTMENT FEES

Company will pay for statutory Appointment fees when:

- Agent meets all Good Standing criteria.
- Agent has active inventory of a minimum of 100 Contracts, which inventory will be evaluated:
    - At the end of the initial twelve (12) month period calculated from the date of appointment; and
    - At the end of every subsequent twelve (12) month period thereafter.
- If the Appointed Agent satisfied this minimum inventory standard, Company will pay to renew their Appointment; however
    - If at any time the Appointed Agent does not satisfy the minimum inventory standard, or the Agent's Appointment is terminated by the State of Florida for any reason, the Appointed Agent may be required to reimburse Company for the Appointment Fees that Company paid on the Agent's behalf.
    - If the Appointed Agent fails to reimburse Company or submit renewal Appointment Fees, Company shall, within 30 calendar days from the date that agent was notified to reimburse Company, terminate the Appointed Agent's Appointment and cease commission payment(s) to the Appointed Agent.

AGENT ATTESTATION

I certify that I have read and understand the items on this form and that the answers to the above questions are true and complete to the best of my knowledge. If accepted, I agree to comply with all the regulations of Capital Health Plan and the State of Florida Office of Insurance Regulation (OIR). I understand and agree that I am not permitted to solicit insurance until I have received my license from the OIR.

By signing below, I certify that I have not been convicted of any criminal felony involving dishonesty, breach of trust, or been convicted of an offense under Section 1033 of the Violent Crime and Law Enforcement Act of 1994. Furthermore, I agree immediately to inform Capital Health Plan of any conviction of the types described in the preceding sentence. Finally, I also understand and agree that my appointment is predicated on my compliance with the corporate policies and procedures of Capital Health Plan including, but not limited to, the provisions of the foregoing “Privacy and Security” and “Good Standing Criteria” sections.

NOTICE: The Fair Credit Reporting Act requires that we advise you that a routine inquiry may be made during our initial or subsequent processing of your application for sponsorship for license that will provide applicable information concerning your health, past history, credit, general reputation, personal characteristics, and mode of living. The information obtained in this inquiry may be released to any third party, including state and federal regulatory bodies. On your written request, additional information about the nature and scope of the inquiry, if one is made, will be provided.

_____

Print Name of Applicant

_____

Signature of Applicant

_____

Date

Capital Health PLAN℠

An Independent Licensee of the Blue Cross and Blue Shield Association

Dear Agent,

In order to better serve you, we are asking you to please provide us with the most current, accurate company and business contact information available.

If you are being added to an *EXISTING* vendor account with CHP:

We have attached for your completion a standardized letter that includes the information we need most when processing an invoice for payment to your existing account. Please take a moment to complete the vendor information profile in the form and fashion requested.

If you need to create a *NEW* vendor account with CHP:

We have attached for your completion a standardized letter that includes the information we need most when processing an invoice for payment or needing a direct contact regarding the status of our account. Please take a moment to complete the vendor information profile in the form and fashion requested.

In order to establish your agency vendor profile for payment, we will need the following:

- **New Vendor Profile on letterhead**
- **Most current IRS Form W-9**
- **ACH Enrollment & Authorization Form (must include a voided check)**

Please note: When filling out the above letter and forms, vendor identification must match. If you are the owner of the Agency and wish for your commissions to be paid directly under your name, you may use your SSN in lieu of a business FEIN. If you are not the owner of the Agency, or you do not wish commissions be paid under your name, you ***must*** use the Agency FEIN to which commissions will be paid.

We sincerely appreciate your prompt attention to this request.

Sincerely,

Mark S. Hicks, Sr.
Director, Sales & Account Management

EXISTING VENDOR PROFILE

PLEASE PROVIDE THIS INFORMATION ON YOUR COMPANY LETTERHEAD

CURRENT DATE

Capital Health Plan
Accounts Payable
PO BOX 15349
Tallahassee, FL 32317

Reference: New Agent to be added to existing Vendor Profile

To: Capital Health Plan:

As requested, we are providing our company profile information below in order to provide you with the most recent information when processing our payment.

Remit commission payments for:

Agent Name: _____

Remit Commission Payments to:

Agency Name: _____
Agency FEID: _____
Agency Vendor ID: _____

Sincerely,

Signature

Name Title

NEW VENDOR PROFILE

PLEASE PROVIDE THIS INFORMATION ON YOUR COMPANY LETTERHEAD

CURRENT DATE

Capital Health Plan
Accounts Payable
PO BOX 15349
Tallahassee, FL 32317

Reference: Vendor Profile

To: Capital Health Plan:

As requested, we are providing our company profile information below in order to provide you with the most recent information when processing our payment.

Mailing Address: Street _____
City _____
State _____ ZIP Code _____

A/P Remit Address: Street _____
City _____
State _____ ZIP Code _____

Telephone Number _____Fax Number _____

FEID Number _____

Business Entity Type (Proprietorship, Partnership, Corporation)

Accounting Department Contact:
Name _____
Title _____
Telephone Number _____
E-mail Address _____

Primary Business Purpose: _____

Sincerely,

Name Title

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 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 generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* 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); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

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 for Part II, later.

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

General Instructions

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

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

By signing the filled-out form, you:

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, and

4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting,* later, for further information.

Note: If you are a U.S. person and 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 under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 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 section 1446 withholding on your share of partnership income.

In the cases below, the following person must give 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.

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items.

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 24% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the instructions for Part II for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code,* later, and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships,* earlier.

What is FATCA Reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code,* later, and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account (other than an account maintained by a foreign financial institution (FFI)), list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9. If you are providing Form W-9 to an FFI to document a joint account, each holder of the account that is a U.S. person must provide a Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note: ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C corporation, or S corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

Check the appropriate box on line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box on line 3.

IF the entity/person on line 1 is a(n) . . .	THEN check the box for . . .
• Corporation	Corporation
• Individual • Sole proprietorship, or • Single-member limited liability company (LLC) owned by an individual and disregarded for U.S. federal tax purposes.	Individual/sole proprietor or single-member LLC
• LLC treated as a partnership for U.S. federal tax purposes, • LLC that has filed Form 8832 or 2553 to be taxed as a corporation, or • LLC that is disregarded as an entity separate from its owner but the owner is another LLC that is not disregarded for U.S. federal tax purposes.	Limited liability company and enter the appropriate tax classification. (P= Partnership; C= C corporation; or S= S corporation)
• Partnership	Partnership
• Trust/estate	Trust/estate

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space on line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)

2—The United States or any of its agencies or instrumentalities

3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

4—A foreign government or any of its political subdivisions, agencies, or instrumentalities

5—A corporation

6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession

7—A futures commission merchant registered with the Commodity Futures Trading Commission

8—A real estate investment trust

9—An entity registered at all times during the tax year under the Investment Company Act of 1940

10—A common trust fund operated by a bank under section 584(a)

11—A financial institution

12—A middleman known in the investment community as a nominee or custodian

13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 5[2]
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a)

J—A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Note: You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns. If this address differs from the one the requester already has on file, write NEW at the top. If a new address is provided, there is still a chance the old address will be used until the payor changes your address in their records.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN.

If you are a single-member LLC that is disregarded as an entity separate from its owner, enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note: See *What Name and Number To Give the Requester,* later, for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at *www.SSA.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/Businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. Go to *www.irs.gov/Forms* to view, download, or print Form W-7 and/or Form SS-4. Or, you can go to *www.irs.gov/OrderForms* to place an order and have Form W-7 and/or SS-4 mailed to you within 10 business days.

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, 4, or 5 below indicates otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code,* earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), ABLE accounts (under section 529A), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account) other than an account maintained by an FFI	The actual owner of the account or, if combined funds, the first individual on the account[1]
3. Two or more U.S. persons (joint account maintained by an FFI)	Each holder of the account
4. Custodial account of a minor (Uniform Gift to Minors Act)	The minor[2]
5. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee[1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner[1]
6. Sole proprietorship or disregarded entity owned by an individual	The owner[3]
7. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
8. Disregarded entity not owned by an individual	The owner
9. A valid trust, estate, or pension trust	Legal entity[4]
10. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
11. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
12. Partnership or multi-member LLC	The partnership
13. A broker or registered nominee	The broker or nominee
14. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
15. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B))	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or DBA name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships,* earlier.

***Note:** The grantor also must provide a Form W-9 to trustee of trust.

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records From Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Pub. 5027, Identity Theft Information for Taxpayers.

Victims of identity theft who are experiencing economic harm or a systemic problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov.* You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at *spam@uce.gov* or report them at *www.ftc.gov/complaint.* You can contact the FTC at *www.ftc.gov/idtheft* or 877-IDTHEFT (877-438-4338). If you have been the victim of identity theft, see *www.IdentityTheft.gov* and Pub. 5027.

Visit *www.irs.gov/IdentityTheft* to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

Capital Health PLAN

An Independent Licensee of the Blue Cross and Blue Shield Association

ACH ENROLLMENT & AUTHORIZATION FORM

VENDOR INFORMATION

Account Status: ☐ Set Up New Account ☐ Change Account Profile

Name_____ FEID Number_____

(Please Print)

BANK INFORMATION

Financial Institution_____ Branch_____

Transit/ABA No._____ Account No._____

Checking_____ Savings_____

(Please Pick One Above)

ATTACHED VERIFICATION OF BANK ACCOUNT AND ROUTING INFORMATION

Attach Voided Check

APPROVAL

I (we) hereby authorize Capital Health Plan, hereinafter called Company, and the depository named below, hereinafter called Financial Institution, to accept credit entries and initiate, if necessary, debit entries and adjustments for any credit entries in error to my (our) Checking/Savings account.

This authority is to remain in full force and effect until Company has received written notification from the authorizing representative of its termination in such time and such manner as to afford Company and Financial Institution a reasonable opportunity to act on it.

Payments for Vendor will be transmitted on a monthly disbursement cycles. In the event of a holiday, the ACH payment will take place the next business day or disbursement cycle. Generally, there is a lag between the time Capital Health Plan processes your disbursement payment, and when your bank posts the transaction. Posting times may vary from bank to bank.

Signature_____ Date_____

Contact Name_____ E-Mail Address_____

Telephone No._____

THIS SECTION WILL BE COMPLETED BY CHP ACCOUNTS PAYABLE DEPARTMENT

Date Received____/____/20____ Date Entered____/____/20____

Entered by_____

Approved by_____

Dear Agents,

Capital Health Plan is excited to inform you about a resource available to you, our agent partners, through CHP*Connect*.

With CHP*Connect* for Brokers, you now have the ability to download your client annual renewals, submit new group proposal requests, download Capital Health Plan forms and documents, view member eligibility, view client premium billing statements, submit secure online transactions and much more!

To register:

- Access our website at www.capitalhealth.com.
- Click on the "**Agent**" tile.
- Select "**Agent Tools**" from the drop down menu.
- Click on "**CHP*Connect*"**.
- Click on the "**Broker**" link found underneath New User Registration.
- Follow registration prompts.
- Sign and return the CHP User Agreement to Sales & Account Management at agent@chp.org.

Please contact our office at 850-523-7333 if you need any assistance registering for CHP*Connect*.

Please note, it is necessary for you to register for CHP*Connect* in order to receive your client renewals and commission statements.

Thank you for your continuous support of Capital Health Plan.

Sincerely,

Capital Health Plan
Sales & Account Management

CHP*Connect*

Broker/ Agent and Agency Agreement

Read these terms carefully. Use of the Site is subject to the terms and conditions set forth herein including certain restrictions on the use of the Service provided through the Site. If you do not agree to these terms and conditions, you may not access or otherwise use the Service and the Site. You will not be allowed access to the Site until Capital Health Plan receives this document. To agree to these terms and conditions, please print them out, sign the acknowledgement on the last page, insert the date and return it to:

Capital Health Plan
CHP*Connect* Administrator
PO Box 15349
Tallahassee, Florida 32317

1. Introduction. The Capital Health Plan/HealthTrio Internet website (the "Site") provides the means for electronic transmission and retrieval of information (the "Service") between you ("User"), as a Broker/Agent facilitating healthcare services to eligible Employer Groups or as an authorized representative of an already participating Employer Group, and CHP ("Capital Health Plan"). As part of the Service, User will have the ability to transmit messages, files, data regarding User, data regarding employer group contracts and/or members enrolled with CHP and other information or to engage in any other form of communication with Capital Health Plan through the Site. User will also have the means to retrieve certain information from certain CHP databases, including but not limited to information necessary to reconcile your monthly commission statement, group renewal rates, new group rate quotes, quarterly table rates, employer group census, etc. The owner of the Site, HealthTrio, Inc. ("HealthTrio"), has established information and uses collection policies that are set forth in the Privacy Policy shown on the Site. Any third party content or information available on or through the Site is provided "as is" and its use is at User's sole risk.

2. User's Obligations. User agrees as follows:

(i) User agrees that he/she is an authorized representative of the Employer Group and/or Broker/ Agency User is applying for CHP*Connect* access and takes full responsibility for the terms & conditions of this Agreement.

(ii) User will not disclose his/her password that allows access to the Site and the System to any third party, co-worker, employer or otherwise. User, and any Employer Group and/or Agency for whom User is an authorized representative, will be responsible for all activity or transactions through the Site that are attributable to User's password.

(iii) User will ensure that any data, text or information that User provides, accesses, or retrieves from Capital Health Plan databases will be used solely in furtherance of the relationship that User and/or the Employer Group and/or Agency for whom User is an authorized representative has with Capital Health Plan.

(iv) User will use best efforts to ensure that any data, text or information, including without limitation, enrollment, payment, billing records, rates, or any Protected Health Information that User provides to, accesses or retrieves from CHP databases will be maintained in confidence and not disclosed to any other party.

(v) User will adhere to the rules set forth in the Capital Health Plan Underwriters Guidelines, Employer Group Contract consisting of, but not limited to, the Master Policy, the Member Handbook, the Group Application, the Individual Application for Group Insurance/ Membership, and any attachments, amendments or endorsements to the Member Handbook or the Master Policy.

(vi) User agrees to submit accurate and complete enrollment, employer group contract renewal, new group rate requests, alternate rate requests, etc. on a timely basis through the Site. User is responsible for collecting and maintaining original forms and documents, including but not limited to, the CHP Employer Applications, new group rate request, medical questionnaires, enrollment applications, change forms, and supporting Member eligibility documentation, etc. and agrees to make any of the above records relevant to eligibility or coverage status of any individual or employer group available to CHP for inspection and copying upon reasonable notice.

(vii) For Broker FTA logins, a login accessing commission schedules, the User agrees to view and/or submit information only pertaining to the reconciliation of the Broker/Agency commissions, commission statements, or any other requisite necessary for the purpose to conduct business on behalf of the Broker/Agency in respect to the payment or transference of commission payments.

(viii) User acknowledges that all right, title and interest in and to the Protected Health Information, the Service, the Site, and the URL associated therewith, including all present and future rights in and to

intellectual property and other proprietary rights of any type are and will continue to be the sole and exclusive property of HealthTrio or Capital Health Plan.

3. Termination. Capital Health Plan may immediately terminate this Agreement and the rights granted to User hereunder, with or without cause, at any time, without notice, and without penalty.

4. General Provisions. Any terms used in this Agreement, and not otherwise defined, will have the meaning used in the Capital Health Plan Notice of Confidentiality pursuant to which User has been given access to the Protected Health Information. This Agreement will not be assigned or otherwise transferred by User without Capital Health Plan's prior written consent. This Agreement contains the entire Agreement between the parties hereto with respect to the matters contained herein and supersedes all prior understandings, whether written or oral, if any, with respect thereto. If any term or provision of this Agreement will be invalid, illegal or unenforceable, the remainder of his Agreement will not be affected thereby. This Agreement may not be modified, terminated or amended nor any of its provisions waived except by a written instrument signed by the party to be charged. Sections 2, 3 and this Section 4 will survive any termination of this Agreement.

This Agreement shall be governed by and interpreted in accordance with Florida State laws.

I hereby acknowledge I have read the above terms and conditions and agree to be bound thereby as a condition of my access to and use of the Service and the Site.

_____ (___)_____
Print User Name Contact Phone

_____/_____
User Signature Date

Agency Name: _____

Agency FEIN(s): _____

_____

Check (✓) the User Profile Required for this User

Broker Admin

Functions*: Add Site Users; Access Group Renewals, Reports; Submit New Group Quote Request; Submit Group Renewal Contract; Access Quarter Rates; View Member Eligibility and Demographics; View Employer Monthly Billing Statement, etc.*

☐ Yes, I will need access to this Role. Below is a list of the appointed agent(s) with Capital Health Plan that I have permission by my employer to access.

1). _____ 5). _____
2). _____ 6). _____
3). _____ 7). _____
4). _____ 8). _____

NOTE: While the User may also be the appointed Agent with Capital Health Plan, one User cannot give access to another User. Each User must read and sign their own individual User Agreement.

Broker FTA

Functions*: View Commissions and Commission Statements*

☐ Yes, I will need access to the Broker FTA. I have permission from my employer for this Role and understand that I will only have access to commission statements assigned to the Agency with the name and address listed on this Agreement.

NOTE: You must register online prior to completing & submitting this Agreement. Agreements will be discarded after 30 days if the User has not registered online via www.capitalhealth.com. Incomplete Agreements will not be accepted. If you do not receive confirmation of your registration within 30 days of this Agreement, please contact the Capital Health Plan, Sales Department at 850-523-7333. Thank you.

Capital Health Plan is not responsible for unauthorized Users or User Access. By registering for CHP*Connect* you affirm entitlement to CHP*Connect* access and hold Capital Health Plan harmless of any errors or omissions made by you or on your behalf.

This is a reminder that you will be assigned the Administrative role in CHP*Connect*.

As the Account Administrator, you will have the responsibility of ensuring that your office staff understands the importance of maintaining the highest level of confidentiality and privacy. This includes accessing CHP*Connect* in a secure environment and handling the website information in the same confidential manner as a client's account record. **Each user should understand that passwords should never be shared and they should only access CHP*Connect* using their individually assigned log-in.**

You also have authorization to revoke a user's access. **We require that access to CHP*Connect* be immediately revoked when an employee leaves your employment.** Untimely access deactivation and/or password sharing creates a breach of confidential information. In order to keep your liability risk and ours at minimum it is essential that you monitor the users and access.

Always Remember:

1. **Each individual must have their own log-in.**
2. **Passwords should never be shared.**
3. **Users no longer in your employment should not have access.**
4. **Any breach of confidentiality should be reported to Capital Health Plan immediately.**

If you have any questions or would like to discuss this further, please contact us at 850-523-7333 or by email, agent@chp.org.

Sincerely,

Capital Health Plan
Sales & Account Management

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("Agreement") is entered into this ____ day of _____, 20___ ("Effective Date"), by and between Capital Health Plan, Inc., a Florida corporation not for profit ("CHP"), and _____, a Licensed Agent _____. ("Business Associate").

RECITALS

1. CHP operates a health maintenance organization and, as a "Covered Entity," is subject to the requirements of federal law, particularly the privacy and security regulations enacted under the Health Insurance Portability and Accountability Act ("Privacy Rule" and "Security Rule") with respect to maintaining the confidentiality of its members' protected health information.

2. Business Associate is engaged to render Agent/ Broker Services _____ _____ to CHP ("Services"), pursuant to , Agent/ Broker Contract _____ and is a "Business Associate" as defined in the Privacy Rule and the Security Rule. From time to time, it may be necessary to the rendition of such services that Business Associate have access to protected health information relating to CHP members.

3. The parties wish to enter into this Agreement as a matter of good practice and to comply with federal law.

STATEMENT OF AGREEMENT

NOW THEREFORE, in consideration of the mutual promises in this Agreement, the parties agree as follows:

SECTION 1. Definitions.
As used in this Agreement, the following terms shall have the meanings set forth below. Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in the Privacy Rule and the Security Rule.

Business Associate. "Business Associate" shall mean _____.
Breach. "Breach" shall have the same meaning as the term "breach" in Sections 13400(1) and 13402 of the HITECH Act and 45 CFR §164.402.

Covered Entity. "Covered Entity" shall mean CHP.

HITECH Act. "HITECH Act" shall mean the Health Information Technology for Economic and Clinical Health Act, enacted as Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009, P.L. 111-5. All references in this Agreement to such Act or to any section thereof shall be deemed to include all applicable regulations and guidance as may be promulgated or issued, respectively, to implement such Act.

Individual. "Individual" shall have the same meaning as the term "individual" in 45 CFR §§160.103 and 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR §164.502(g).

Privacy Rule. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E as in effect on the date of this Agreement and as subsequently amended.

Security Rule. "Security Rule" shall mean the Standards for the Protection of Electronic Protected Health Information, 45 CFR Part 160 and 164, Subparts A and C, as in effect on the date of this Agreement and as subsequently amended.

Security Incident. "Security Incident" shall have the same meaning as the term "security incident" as used in 45 CFR §164.304.

Protected Health Information. "Protected Health Information" or "PHI" shall have the same meaning as the term "protected health information" in 45 CFR §§160.103 and 164.501, limited to the information created, received, maintained, or transmitted by Business Associate from or on behalf of CHP, and includes Electronic Protected Health Information.

Electronic Protected Health Information. "Electronic Protected Health Information" shall have the same meaning as "electronic protected health information" in 45 CFR §§160.103 and 164.501, limited to the information created, received, maintained, or transmitted by Business Associate from or on behalf of CHP.

Safeguards. The terms "Administrative Safeguards," "Technical Safeguards," and "Physical Safeguards" shall have the same meaning as those terms in 45 CFR §164.304.

Required by Law. "Required by Law" shall have the same meaning as the term "required by law" in 45 CFR §164.501.

Secretary. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.

Subcontractor. "Subcontractor" shall have the same meaning as the term "subcontractor" in 45 CFR §160.103.

SECTION 2. Obligations and Activities of Business Associate.

Business Associate agrees to the following:

a. **Not to Use or Disclose PHI Unless Permitted or Required.** Business Associate agrees to not request, use, or disclose Protected Health Information other than as permitted or required by the Agreement, or as Required by Law, or as otherwise authorized by CHP. Business Associate may use or disclose Protected Health Information only if such use or disclosure, respectively:

(i) is in full compliance with each applicable requirement of Section 164.504(e) of Title 45, Code of Federal Regulations; and

(ii) would not violate the Privacy Rule if made by CHP.

b. **Use Safeguards.** Business Associate agrees to use appropriate safeguards, as required by the Privacy Rule, to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement. Business Associate will implement Administrative Safeguards, Technical Safeguards, and Physical Safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of any Electronic Protected Health Information that Business Associate creates, receives, maintains, or transmits on behalf of CHP. Without limiting the generality of the foregoing, Business Associate shall implement reasonable and appropriate policies and procedures to comply with, and shall comply with, the provisions of the Security Rule made applicable to Business Associate by the HITECH Act, including without limitation 45 CFR §§164.308, 164.310, 164.312, and 164.316.

c. **Mitigate Harmful Effects.** Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.

d. **Report Unpermitted Uses and Disclosures of PHI.** Business Associate agrees to report to CHP, without unreasonable delay, (i) any use or disclosure of the Protected Health Information not provided for by this Agreement, and (ii) any pattern of activity or practice of any of Business Associate's agents or subcontractors that constitutes a material breach of Business Associates obligations under this Agreement, of which it becomes aware. Business Associate also agrees to report to CHP, without unreasonable delay, any Security Incident of which Business Associate becomes aware. Without limiting the generality of the foregoing, Business Associate shall notify CHP of any Breach as required by Sections 13402 and 13407 of the HITECH Act and by 45 CFR Part 164 Subpart D; provided, however, that such notification to CHP shall be made not less than seventy-two (72) hours upon Business Associate's discovery of such Breach. Business Associate shall also consult and cooperate with CHP with respect to Business Associate's investigation of any Breach. Business Associate, in compliance with Section 13404(b) of the HITECH Act, shall comply with 45 CFR §164.504(e)(1)(ii), by acting as required by that section with respect to any pattern of activity or practice of CHP that constitutes a material breach of CHP's obligations as a covered entity with respect to Protected Health Information.

e. **Compliance of Subcontractors.** Business Associate agrees to ensure that any Subcontractor that receives, creates, maintains, or transmits Protected Health Information from or on behalf of Business Associate, implements reasonable and appropriate policies, procedures, and safeguards consistent with the Privacy Rule and the Security Rule, to protect the confidentiality, integrity, and availability of Protected Health Information, and agrees in writing to the substantially similar restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.

f. **Provide Access.** Business Associate agrees to provide access, during normal business hours, to Protected Health Information in a Designated Record Set of CHP to CHP in order to meet the requirements of 45 CFR §164.524, provided CHP delivers written notice to Business Associate, at least five business days in advance, requesting such access. Business Associate shall, if requested, provide access in the form of an electronic copy of any such Protected Health Information maintained as an electronic health record, as required by Section 13405(e) of the HITECH Act. This provision does not apply if Business Associate and its employees, subcontractors, and agents have no Protected Health Information in a Designated Record Set of CHP or if the Protected Health Information held by Business Associate merely duplicates information held by CHP.

g. **Incorporate Amendments.** Business Associate agrees to incorporate any amendment(s) to Protected Health Information in a Designated Record Set of CHP that CHP directs pursuant to 45 CFR §164.526. This provision does not apply if Business Associate and its employees, subcontractors, and agents have no Protected Health Information in a Designated Record Set of CHP or if the Protected Health Information held by Business Associate merely duplicates information held by CHP.

h. **Disclose Practices, Books, and Records.** Unless otherwise protected or prohibited from discovery or disclosure by law, Business Associate agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information created, received, maintained, or transmitted by Business Associate from or on behalf of CHP, available to the Secretary, upon reasonable notice, for purposes of the Secretary determining CHP's compliance with the Privacy Rule or the Security Rule. Business Associate shall have a reasonable time within which to comply with requests for such access and in no case shall access be required in less than five business days after Business Associate's receipt of such request, unless otherwise designated by the Secretary.

i. **Document Disclosures.** Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for CHP or Business Associate to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with Section 13405 of the HITECH Act and 45 CFR §164.528. To that end, unless otherwise protected or prohibited from discovery or disclosure by law, Business Associate agrees to provide to CHP or directly to an Individual, as directed by CHP pursuant to Section 13405(c)(3) of the HITECH Act, upon reasonable notice, information thus collected, to respond, or to permit CHP to respond, to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with Section 13405 of the HITCECH Act and 45 CFR §164.528. If Business Associate receives any request for access, amendment, accounting of disclosure, or other similar request directly from an Individual, Business Associate will promptly notify CHP of such request.

j. **Restrictions on Disclosures.** If Business Associate receives from any Individual a request to restrict uses or disclosures of an Individual's Protected Health

Information, Business Associate will promptly notify CHP of such request. Business Associate will comply with directions from CHP to restrict the use or disclosure of Protected Health Information for an Individual if CHP advises Business Associate that CHP must comply with such restrictions as required by Section 13405 of the HITECH Act and 45 CFR §164.522(a)(1)(vi).

k. **No Remuneration.** Except (i) when specifically authorized in writing, in advance, by CHP or (ii) to provide an individual a copy of that individual's Protected Health Information pursuant to 45 CFR §164.524, at no more than actual cost, Business Associate shall receive no remuneration, directly or indirectly, in exchange for any Protected Health Information of an individual.

l. **Delegated Functions.** To the extent Business Associate is to carry out one or more of a covered entity's obligation(s) under Subpart E of 45 CFR Part 164, Business Associate shall comply with the requirements of Subpart E that apply to that covered entity in the performance of such obligation(s).

m. **Cost Reimbursement.** In the event of a Breach or violation caused solely by Business Associate or its employees or subcontractors, Business Associate agrees to reimburse CHP for the reasonable and substantiated costs related to the following: providing notifications to affected individuals, the media, or the Secretary; providing credit monitoring services to the affected individuals, if appropriate of up to one (1) year; any fines and penalties assessed against CHP, including but not limited to the circumstance described by 45 CFR §160.402(c)(1); investigation costs; and mitigation efforts required under the Privacy and Security Rule. This provision shall not be construed or interpreted to limit any other duty or liability Business Associate may have to CHP under applicable law.

n. **DMS Cooperation.** Pursuant to section 20.055(5), Florida Statute, Business Associate understands and agrees to cooperate with the Department of Management Service's inspector general in any investigation, audit, inspection, review, or hearing pursuant to this section.

o. **E-Verify System.** Pursuant to section 448.095, Florida Statutes, Business Associate has an obligation to utilize the U.S. Department of Homeland Security's (DHS) E-Verify system for all newly hired employees. By entering into this Business Associate Agreement, Business Associate certifies that it is registered with, and uses, the E-Verify system for all newly hired employees. Business Associate will complete the Section 448.095(2)(b) Affidavit attached hereto and return to CHP. Business Associate will additionally provide CHP with a copy of its DHS Memorandum of Understanding (MOU) regarding the E-Verify system within fifteen (15) days of the Effective Date.

SECTION 3. Permitted Uses and Disclosures by Business Associate.

Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information in the course of providing the Services described herein, if such use or disclosure of Protected Health Information would not violate the Privacy Rule or the Security Rule or other applicable law if done by CHP, or violate policies and procedures of CHP requiring Protected Health Information to be disclosed only to the

minimum necessary extent. CHP shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule or the Security Rule if done by CHP. All requests, uses, and disclosures by Business Associate for or of Protected Health Information shall be the minimum necessary to accomplish the intended purpose of such request, use, or disclosure in accordance with Section 13405(b) of the HITECH Act and 45 CFR §164.502(b)(1). Business Associate shall develop and implement internal policies, procedures, and protocols that are consistent with the requirements of 45 CFR §164.512(d), in order to limit its requests for, and its use and disclosure of, PHI to the minimum necessary to accomplish the intended purpose of such request, use, or disclosure.

SECTION 4. Obligations of CHP

a. **Notice of Privacy Practices.** CHP shall notify Business Associate of any limitation(s) in its notice of privacy practices of CHP in accordance with 45 CFR §164.520, to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information.
b. **Notice of Changes in Permission.** CHP shall notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes may affect Business Associate's use or disclosure of Protected Health Information.
c. **Notice of Other Restrictions.** CHP shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that CHP is required to honor pursuant to the HITECH Act, or that CHP has agreed to in accordance with 45 CFR §164.522, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.

SECTION 5. Term and Termination

a. **Term.** The Term of this Agreement shall be effective as of _____, or the date upon which Business Associate is first engaged to provide the Services described herein, if later, and shall terminate when all of the Protected Health Information created, received, or maintained by Business Associate from or on behalf of CHP, is destroyed or returned, as applicable, to CHP, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section.
b. **Termination for Cause.** Upon a party's reasonable determination of a material violation of this agreement by the other party, the non-breaching party shall give written notice of such violation to the breaching party and either:
   Provide an opportunity for the breaching party to cure or end the violation, as appropriate in the non-breaching party's reasonable judgment, and terminate this Agreement if the breaching party does not cure or end the violation within the time specified by the non-breaching party; or
   Immediately terminate this Agreement if the breaching party has violated a material term of this Agreement, termination is feasible, and cure is not possible.

c. **Effect of Termination.** Except as provided in paragraph (c)(ii) of this section, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all Protected Health Information created, received, or maintained by Business Associate from or on behalf of CHP. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

i In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide, as applicable, to CHP notification of the conditions that make return or destruction infeasible. Upon notice that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

ii Termination of this Agreement because of Business Associate's material, uncured breach shall constitute grounds for CHP to terminate, without liability to Business Associate by reason of such termination, the underlying business relationship, including any contract, between CHP and Business Associate, to the extent applicable.

SECTION 6. Miscellaneous

a. **Regulatory References.** A reference in this Agreement to a section in the Privacy Rule or the Security Rule means the section as in effect or as amended.
b. **Amendment.** The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for CHP to comply with the requirements of the Privacy Rule, the Security Rule, the HITECH Act, and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, as they may be amended from time to time.
c. **Survival.** The respective rights and obligations of Business Associate under Section 5(c) of this Agreement shall survive the termination of this Agreement.
d. **Interpretation.** Any ambiguity in this Agreement shall be resolved to permit CHP to comply with the Privacy Rule, the Security Rule, and other applicable law governing the privacy and security of health information.

IN WITNESS WHEREOF, the parties have executed and delivered this Agreement on the date first above written.

CAPITAL HEALTH PLAN, INC.

By: _____
Signature

Frank C. Kaminski

As its: Compliance & Privacy Officer

Date: _____

Email Address:

fckaminski@chp.org

Mailing Address:

Capital Health Plan
2140 Centerville Place
Tallahassee, Florida 32308

_____
(Business Associate)

By: _____
Signature

_____
Printed Name

As its: _____

Date: _____

Email Address:

_____

Mailing Address:

_____
Company Name

_____
Street Name

_____
Post Office Box

_____
City

_____
State

_____
Zip Code

Revision History:
Compliance Committee Approved: 4/23/2002, 3/23/2021
Reviewed - No Changes: 5/17/2011, 5/20/2014, 8/25/2015
Revised: 2/25/2009, 8/25/2009, 2/19/2013, 4/30/2013, 8/23/2016, 03/23/2021
Policy Location (s): Compliance Intranet – Business Associate Agreement

SECTION 448.095(2)(b), FLORIDA STATUTE AFFIDAVIT

STATE OF _____
COUNTY OF _____

Before me, the undersigned officer authorized to administer oaths, appears _____, who, upon being sworn, deposes and says:

1. My name is _____. I am over 18 years and competent for all legal purposes.

2. I am an authorized representative of Business Associate for purposes of this affidavit and the Business Associate Agreement entered into with Capital Health Plan, Inc.

3. _____ (Business Associate) does not employ, contract with, or subcontract with an unauthorized alien.

This _____ day of _____, 20___.

_____
Signature of Business Associate Representative

_____
Name of Business Associate Representative

_____
Business Associate Company/Entity Name

STATE OF _____
COUNTY OF _____

Sworn to (or affirmed) and subscribed before me, by means of (___) physical presence or (___) online notarization, this _____ day of _____, 20___, by _____.

_____
Notary Public

_____
Name stamped, printed or type written

My commission expires: _____

Personally known: ____
Produced identification: ____
Type of identification produced: _____