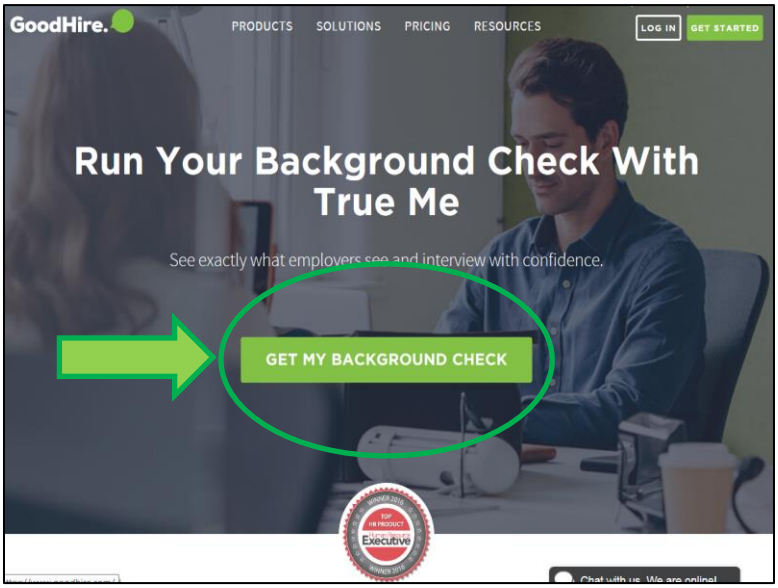
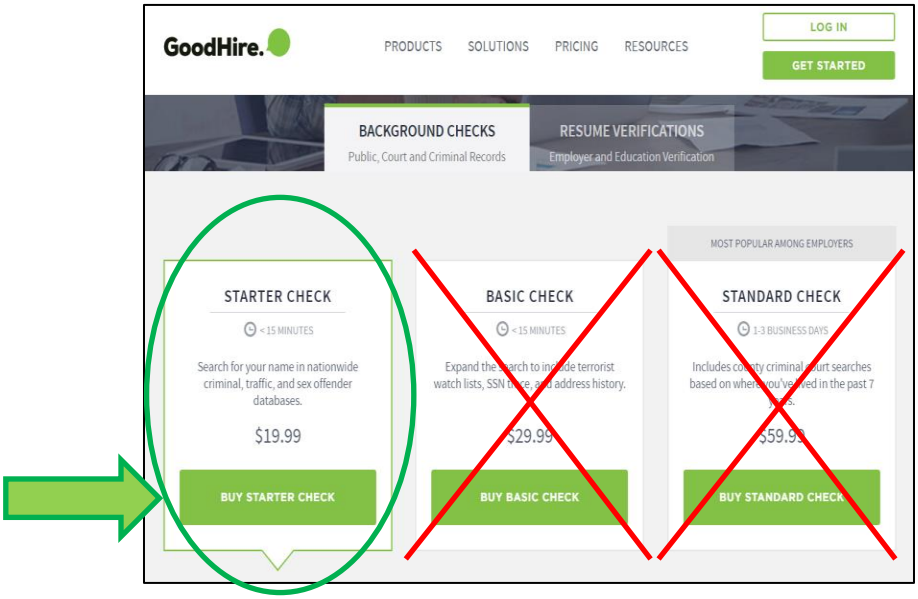
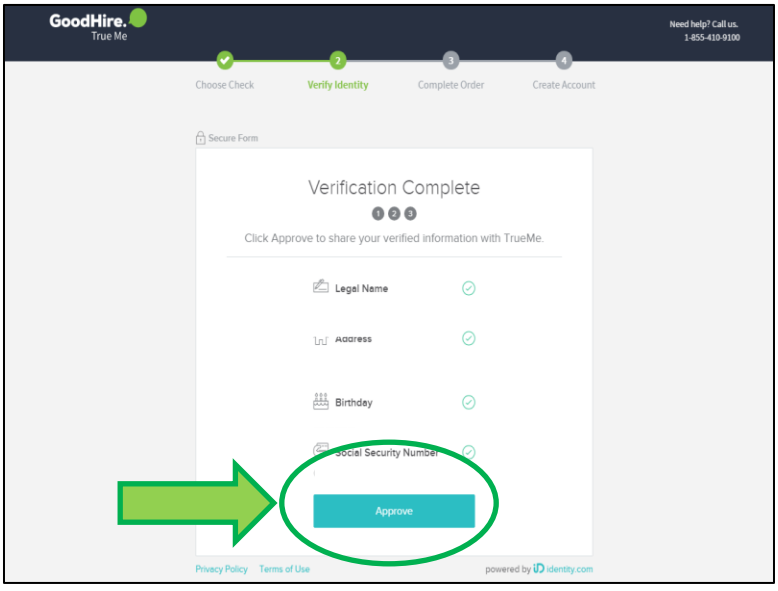
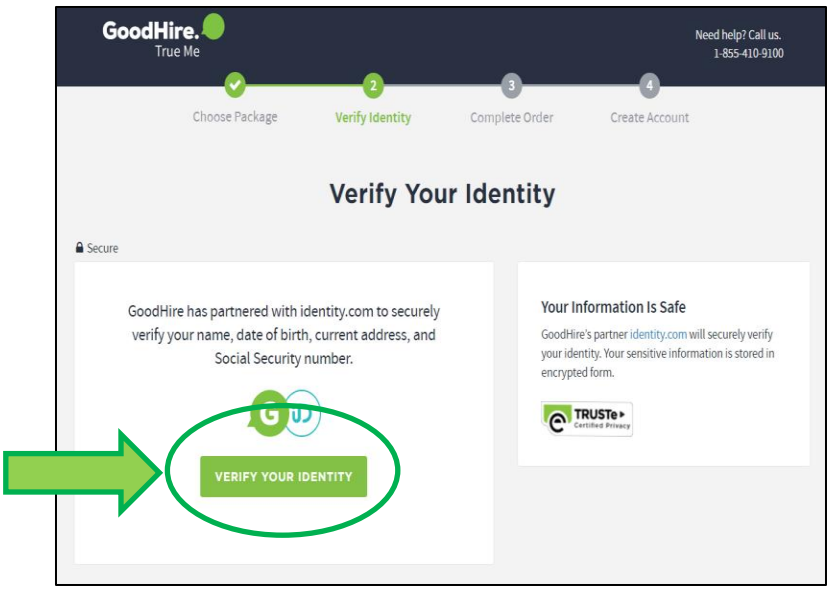
https://trueme.goodhire.com

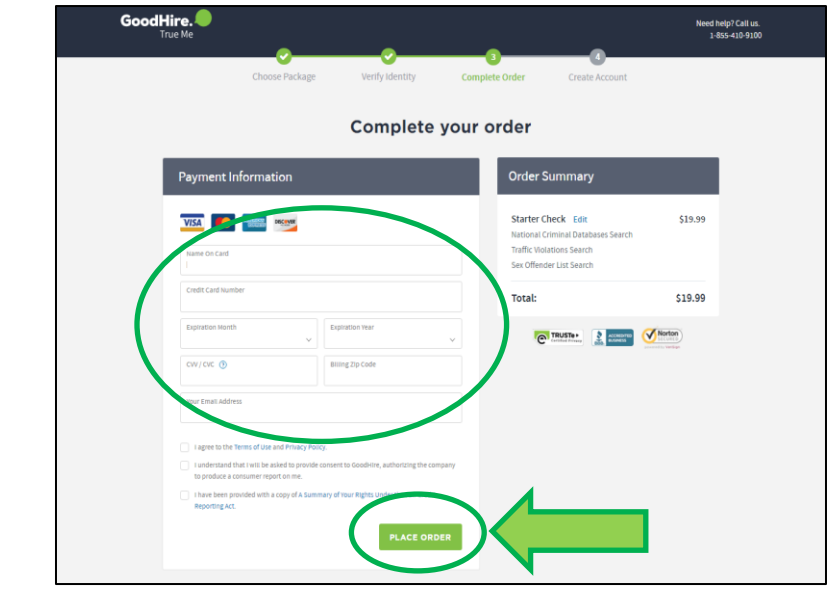


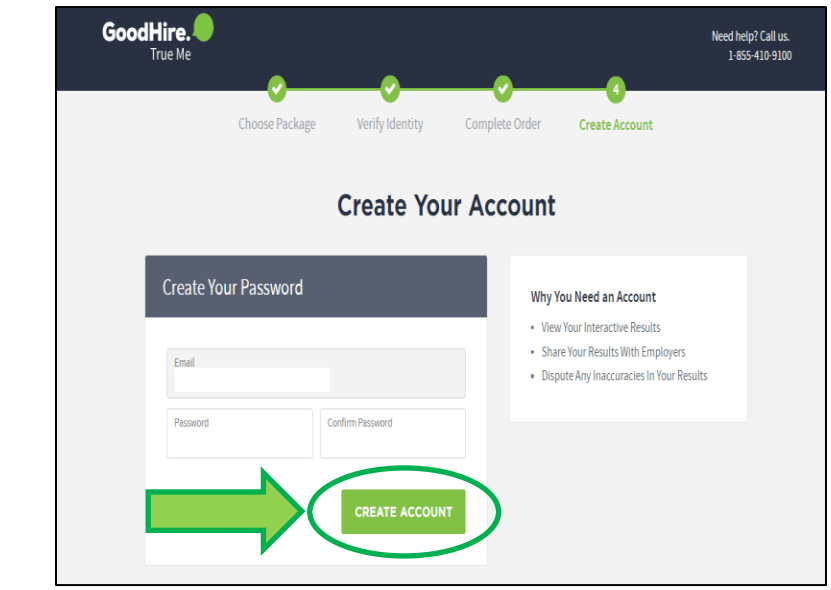
Select ***STARTER CHECK***

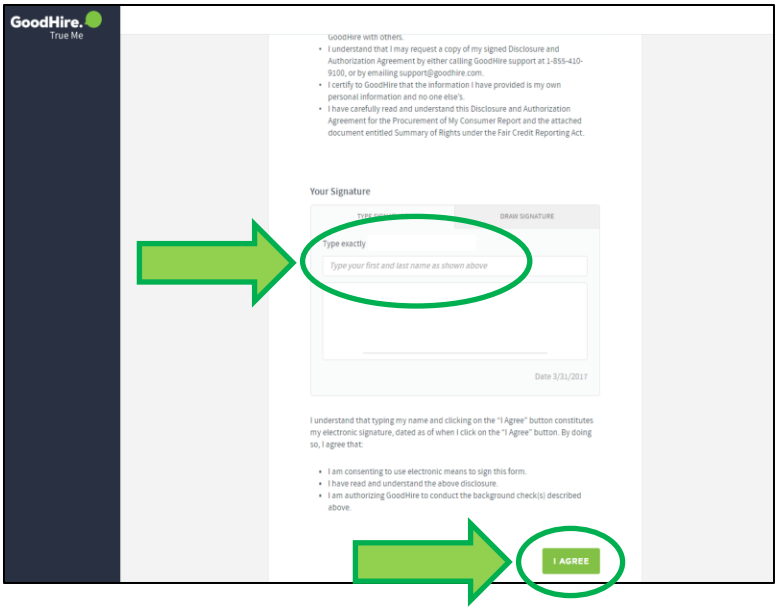


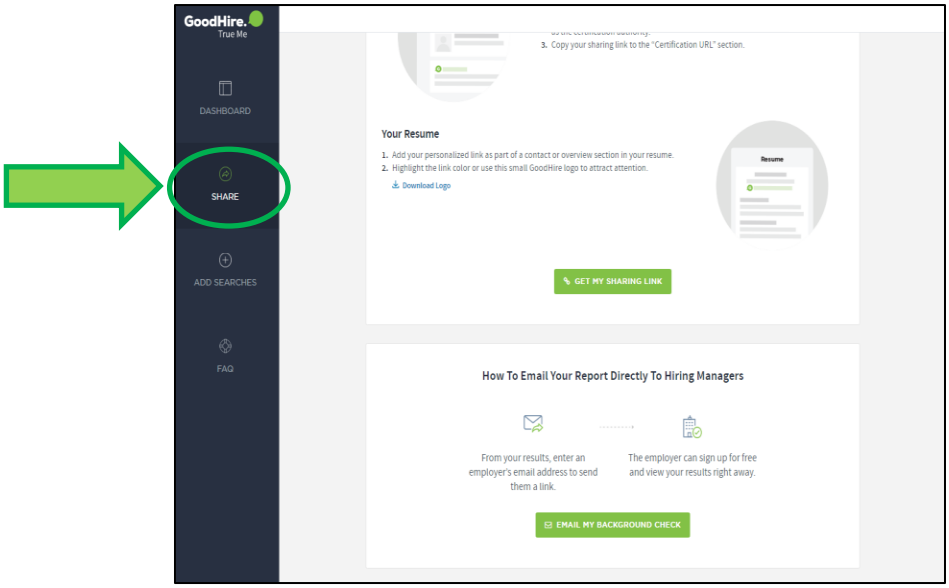



GoodHire.
True Me
Need help? Call us.
1-855-410-9100
Choose Package
2
Verify Identity
3
Complete Order
4
Create Account
Verify Your Identity
Secure
GoodHire has partnered with identity.com to securely verify your name, date of birth, current address, and Social Security number.
VERIFY YOUR IDENTITY
Your Information Is Safe
GoodHire's partner identity.com will securely verify your identity. Your sensitive information is stored in encrypted form.
TRUSTe
Certified Privacy

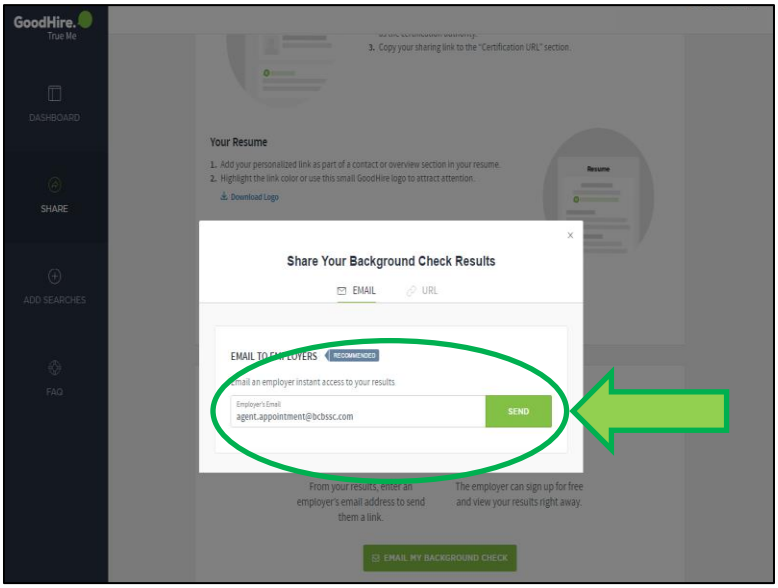

GoodHire.
True Me
Need help? Call us.
1-855-410-9100
Choose Package
Verify Identity
3
Complete Order
4
Create Account
Complete your order
Payment Information
Order Summary
Starter Check
Edit
$19.99
National Criminal Databases Search
Traffic Violations Search
Sex Offender List Search
Total:
$19.99
PLACE ORDER

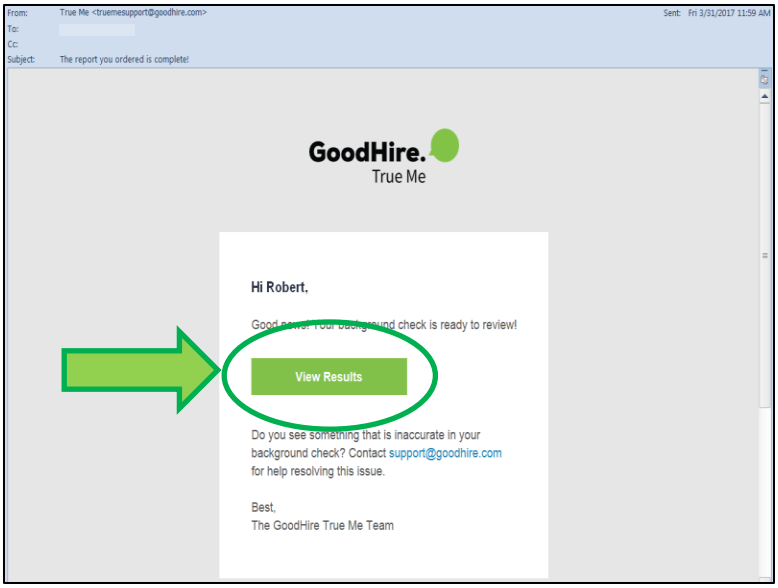

GoodHire.
True Me
Need help? Call us.
1-855-410-9100
Choose Package
Verify Identity
Complete Order
4
Create Account
Create Your Account
Create Your Password
Email
Password
Confirm Password
CREATE ACCOUNT
Why You Need an Account
View Your Interactive Results
Share Your Results With Employers
Dispute Any Inaccuracies In Your Results



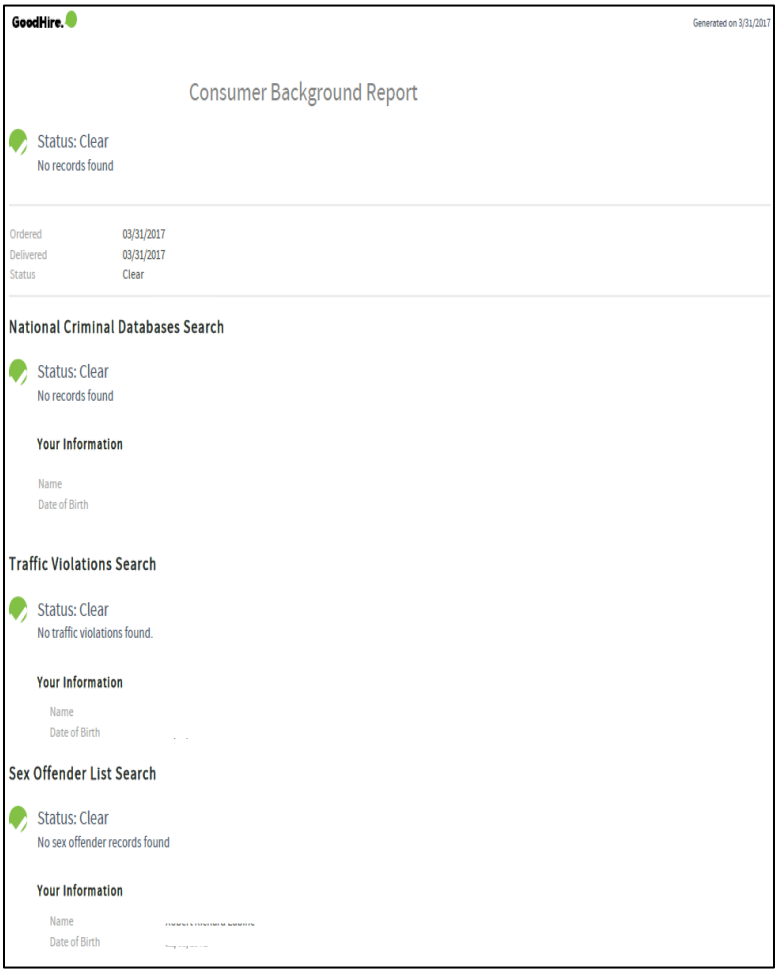


Share results with agent.appointment@bcbssc.com





Results page view



South Carolina

BlueCross BlueShield of South Carolina
is an independent licensee of the
Blue Cross and Blue Shield Association

Agent Hierarchy

Agent Name: _____

General Agency
(GA) Name: _____

Managing General Agency
(MGA) Name: _____

Field Marketing Organization
(FMO) Name: _____

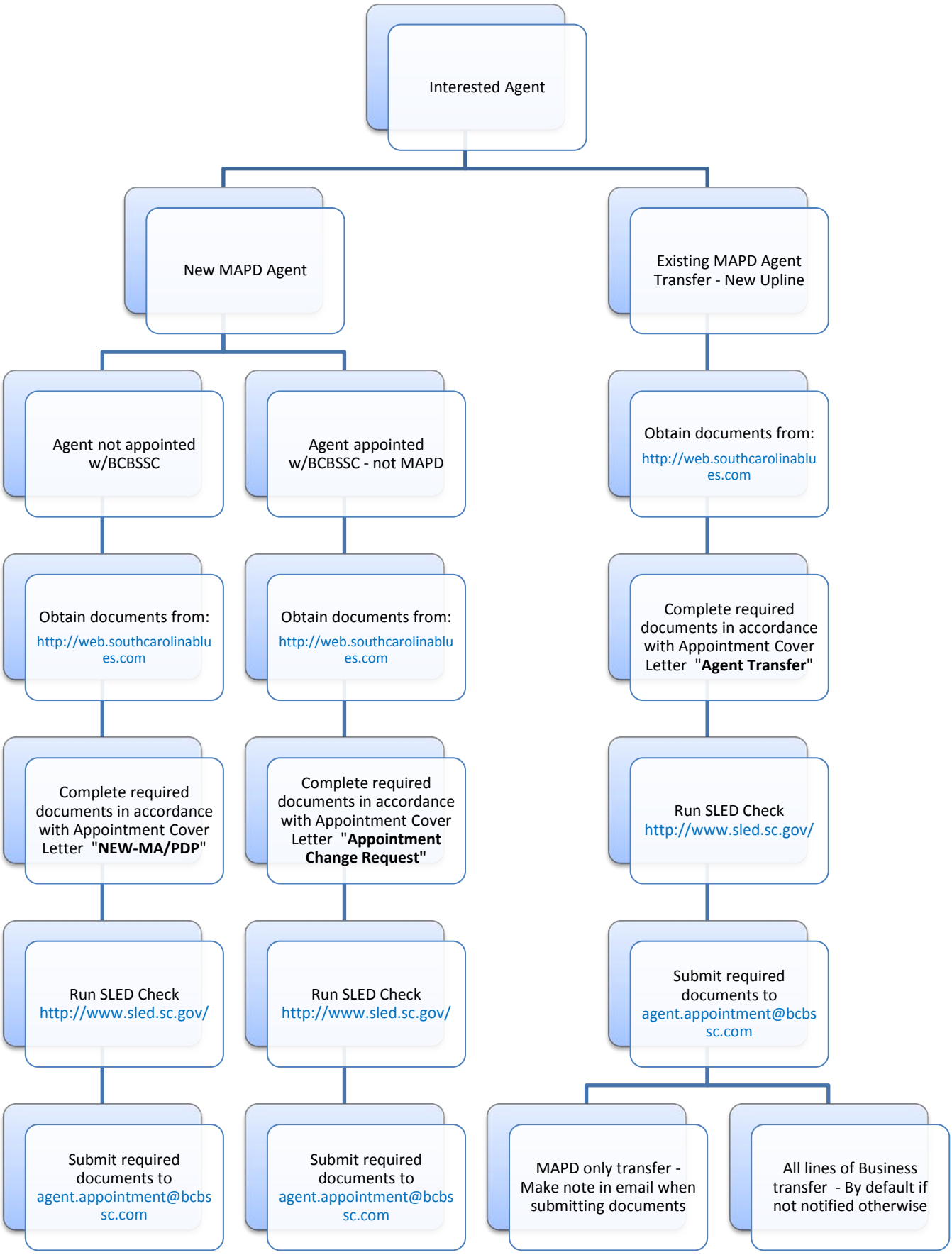
Agent Signature: _____ Date: _____

2017 BCBSSC Medicare Advantage Contracting Guide

Document Name	New BCBS Agent	Existing BCBS Agent	Agent Transfer	Agency Contract
	Not Contracted to Sell any BCBSSC Products	Sells Other BCBSSC Products	Sells Other BCBSSC Products- Wants to Change Up-line	New Agency
Sled Check	**X**	**X**	**X**	
Appointment Cover letter	**X-Check "New Appointment" Box**	**X- Check "Appointment Change" Box**	**X- Check "Appointment Transfer" Box**	
Agency Agreement				**X**
Producer Appointment Application	**X**	**X**	**X**	
Producer Appointment Agreement	**X**		**X**	
W-9	**X**		**X**	**X**
Commissions Assignment Agreement	**X**		**X**	
Electronic Funds Transfer Request for Producer Commissions	**X**		**X**	**X**
Agreement With Business Associate	**X**		**X**	**X**
Copy of E&O	**X**		**X**	**X**

1. Obtain contracting documents from: http://web.southcarolinablues.com
2. Obtain SLED check from: http://www.sled.sc.gov
3. Submit contracting documents to: agent.appointment@bcbssc.com
4. Appointment related questions: Call our appointment team at 803-264-2791
5. Also, feel free to contact Anna Ziegler directly at 803-264-9573 or email anna.ziegler@bcbssc.com

BlueCross BlueShield of South Carolina - MAPD/PDP Contracting & Appointment Steps



Email all completed paperwork and documents to: agent.appointment@bcbssc.com

BlueCross BlueShield of South Carolina and
BlueChoice HealthPlan of South Carolina

Independent licensees of the Blue Cross and Blue Shield Association

APPOINTMENT COVER LETTER

I am requesting review of appointment with BlueCross BlueShield of South Carolina and/or BlueChoice HealthPlan of South Carolina, Inc. ("BlueCross"). This cover letter is to be submitted along with all documents outlined on the Appointment Document Checklist for the action being requested. ***(Select only the appropriate request below)***

1. ☐ **NEW APPOINTMENT:** I, _____, am requesting a new appointment through the following agency, _____, with BlueCross for the following products: ***(Select all that apply)***

BlueCross BlueShield of South Carolina
- ☐ Individual
  - ☐ Medicare Supplement
- ☐ Small Group
- ☐ Large Group
- ☐ Medicare Advantage

BlueChoice HealthPlan
- ☐ Individual
- ☐ Small Group
- ☐ Large Group

☐ **Companion Life -** Life insurance is offered by Companion Life. Because Companion Life Is a separate company from BlueCross and BlueChoice HealthPlan, Companion Life will be responsible for all services related to life insurance.

2. ☐ **APPOINTMENT CHANGE REQUEST:** I, _____ (BlueCross ID#: _____), am requesting that my current appointment with BlueCross be changed to include the following products: ***(Select only those being added)***

BlueCross BlueShield of South Carolina
- ☐ Individual
  - ☐ Medicare Supplement
- ☐ Small Group
- ☐ Large Group
- ☐ Medicare Advantage

BlueChoice HealthPlan
- ☐ Individual
- ☐ Small Group
- ☐ Large Group

☐ **Companion Life -** Life insurance is offered by Companion Life. Because Companion Life Is a separate company from BlueCross and BlueChoice HealthPlan, Companion Life will be responsible for all services related to life insurance.

3. ☐ **APPOINTMENT TRANSFER:** I, _____, am requesting transfer of my current appointment with BlueCross be transferred from my current agency, _____, to _____ and include the following products: ***(Select all that apply)***

BlueCross BlueShield of South Carolina
- ☐ Individual
  - ☐ Medicare Supplement
- ☐ Small Group
- ☐ Large Group
- ☐ Medicare Advantage

BlueChoice HealthPlan
- ☐ Individual
- ☐ Small Group
- ☐ Large Group

☐ **Companion Life -** Life insurance is offered by Companion Life. Because Companion Life Is a separate company from BlueCross and BlueChoice HealthPlan, Companion Life will be responsible for all services related to life insurance.

I understand that completion of these requested actions are contingent upon approval by BlueCross management, favorable results on my background investigations and completion of all required training. I understand that I will be notified once my appointment is finalized and until such notification, I am not authorized to solicit, market, negotiate or sell the products that I am requesting be added to my current appointment.

Forms MUST be completed in their entirety, saved and emailed to Agent.Appointment@bcbssc.com.
For questions concerning Agent Appointments, please email Appointment.Inquiry@bcbssc.com.

DOCUMENT CHECKLIST

(X = Document Required; #=See note w/document to determine requirement)

AGENT APPOINTMENT	**Individual Only**	**Individual & Group**	**MA/PDP**	**Agent Transfer**	**Appointment Change Request**
☐ **Producer Appointment Application** (2 - 1 yr. experience required) (3 – Required if original appointment is more than 1 year old)	X	X	2	X	3
☐ **Producer Appointment Agreement**	X	X	X	X	
☐ **Agreement with Business Associate**	X	X	X	X	
☐ **Errors & Omissions Coverage** ***(Certificate or Declaration Page)*** If you wish to purchase E&O Insurance through our sponsored program, visit www.bcs-eo.com/sc or call 1-866-389-0022.	X	X	X	X	
☐ **SLED Check** ***(Results Page, w/in 30 days of submission)*** producers must run SLED CATCH check at http://www.sled.sc.gov/ and submit results as part of application. (4 - adding MA/PDP to existing appointment)	X	X	X		4
☐ **Commission Assignment Agreement**	X	X	X	X	
☐ **Electronic Funds Transfer Request for Producers Commissions** ***(w/voided Check)***	X	X	X	X	
☐ **W-9 Form** (1 - If being paid directly; not through agency)	1	1	1	1	

AGENCY APPOINTMENT	**Individual Only**	**Individual & Group**	**MA/PDP**
☐ **Agency Appointment Agreement**	X	X	X
☐ **Agreement with Business Associate**	X	X	X
☐ **Errors & Omissions Coverage** ***(Certificate or Declaration page)*** If you wish to purchase E&O Insurance through our sponsored program, visit www.bcs-eo.com/sc or call 1-866-389-0022.	X	X	X
☐ **Electronic Funds Transfer Request for Producers Commissions** ***(w/voided Check)***	X	X	X
☐ **W-9 Form**	X	X	X

☐ I Accept, Electronic Signature. By selecting "I Accept" you are signing this document electronically. You agree your electronic signature is the legal equivalent of your manual/handwritten signature on this document. By selecting "I Accept" using any device, means or action, you consent to the legally binding terms and conditions of this document. You further agree that your signature on this document (hereafter referred to as your "E-Signature") is as valid as if you signed the document in writing. You also agree that no certification authority or other third party verification is necessary to validate your E-Signature, and that the lack of such certification or third party verification will not in any way affect the enforceability of your E-Signature or any resulting document between you and BlueCross BlueShield of South Carolina.

E-Signature: _____

SC DOI License #_____

NPN:_____

Date:_____

Forms MUST be completed in their entirety, saved and emailed to Agent.Appointment@bcbssc.com.

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BlueCross BlueShield of South Carolina and
BlueChoice HealthPlan of South Carolina

Independent licensees of the Blue Cross and Blue Shield Association

PRODUCER APPOINTMENT APPLICATION (Please specify the products for which appointment is being requested):

BlueCross BlueShield of South Carolina

- ☐ Individual
  - ☐ Medicare Supplement
- ☐ Small Group
  - ☐ Chamber
- ☐ Large Group
- ☐ Medicare Advantage

BlueChoice HealthPlan

- ☐ Individual
- ☐ Small Group
- ☐ Large Group

☐ **Companion Life** - Life insurance is offered by Companion Life. Because Companion Life Is a separate company from BlueCross and BlueChoice HealthPlan, Companion Life will be responsible for all services related to life insurance.

Personal Information

Name: (Last, First, Middle Initial)	Date of Birth: (DOB)	Social Security Number:

Home Address: (Including ZIP)	County of Residence:

Home Phone Number:	Cell Number:

Business Mailing Address: (Including ZIP)	County of Business:

Business Physical Address: (No P.O. Boxes)

Business Phone Number:	Fax Number:

Email Address:

Insurance License Information

National Producer Number (NPN):	Federally Facilitated Marketplace (FFM) User ID:

SC DOI License Number:

SC DOI Licensure ☐ Life ☐ Health

Recruiting Agency Name:	Recruiting Agency Number:

Number of contracts (individual and/or group) you anticipate writing each year:

Insurance Experience

Please provide information about companies for whom you have sold or are presently selling Life, Health or Medicare Advantage Insurance.

Company Name	Home Office Location (City and State)	Annualized Production	Persistency	During Period DATE-TO-DATE		Product Sold
			0%		TO	

Forms MUST be completed in their entirety, saved and emailed to Agent.Appointment@bcbssc.com.
For questions concerning Agent Appointments, please email Appointment.Inquiry@bcbssc.com.com.

			0%		TO		
			0%		TO		

Comments:

General Information

☐ Yes ☐ No Have you previously been, or are you now, an appointed agent with any Company? If yes, please give dates and state if active or terminated.

☐ Yes ☐ No Have you ever had your Insurance License refused, suspended or revoked, or been placed on probation, reprimanded or fined by any State Insurance Department? If yes, please explain.

☐ Yes ☐ No Have you ever had a complaint filed against you or ever been investigated by a State Insurance Department or Securities Agency? If yes, please explain.

☐ Yes ☐ No Has an Insurance Company ever cancelled or terminated your contract for reasons other than for lack of production? If yes, please explain.

☐ Yes ☐ No Do you carry an Errors & Omissions Policy? If yes, list Carrier's name, Policy number and amount of coverage.

☐ Yes ☐ No Have you ever been convicted or are you currently under investigation of a felony or any crime under the Violent Crime Control and Law Enforcement Act of 1994 (18 United State Code, 1033 and 1034)? If yes, please explain and attach court records.

☐ Yes ☐ No Do you currently have, or have you in the past five years had, any civil judgments, garnishments or tax liens filed against you? If yes, please explain.

☐ Yes ☐ No Have you ever had a bond cancelled or refused? If yes, please explain.

☐ Yes ☐ No Have you ever filed for, or been declared bankrupt or insolvent, either personally or in business? If so, when? Please explain.

☐ Yes ☐ No Are you currently on, or have you ever received financing, annualization, advance commissions or authority to deposit applicants' checks in your own account with any Company? If yes, list Companies.

☐ Yes ☐ No Do you have an outstanding debit balance with any Insurance Company, Agency or any third party? If yes, list Companies and amounts.

Statements of Understanding

Until such time I am properly licensed, appointed or certified by the State Insurance Department, I will not, (1) solicit applications for insurance for the Companies from whom I am seeking appointment, in any state, or (2) represent myself as an agent or an employee of those Companies, in any way whatsoever.

I understand that if I do solicit applications for insurance without first being authorized and appointed by the Companies, I may be in violation of those Companies' regulations, and Insurance Department regulations, for which severe fines can be levied, and I will be held solely and singularly liable for any claim incurred (or any liability which may arise) from any application or policy which may have been written or sold in violation of any State Department regulations or the rules of the Companies. I understand that the Companies may be bound to report all violations of State Insurance Department regulations as they occur. I understand that until I am properly appointed, no supplies of any kind may be provided to me by the Companies, other than supplies marked "Sample" or "Specimen." I understand that if fines, penalties or damages are imposed against the Companies for any of my acts or omissions, I will be solely liable for those fines, penalties and/or damages. I understand any omission or misrepresentation by me in this application is cause for immediate revocation of my appointment from the Companies.

In making this application for appointment, the Companies may obtain a criminal background report from a consumer-reporting agency, as defined by Fair Credit Reporting Act (Public Law 91-508). As part of this process information is obtained through personal interviews with third parties, such as family members, business associates, financial sources, friends, neighbors or others with whom I

am acquainted. This report will be used for appointment purposes only. I understand that I have the right to make a written request within a reasonable period of time for a complete and accurate disclosure of addition information concerning the nature and scope of this investigation. I have read and understand the above disclosure and hereby authorize Blue Cross and Blue Shield of South Carolina to obtain a criminal background report and/or a personal credit report.

☐ I Accept, Electronic Signature. By selecting "I Accept" you are signing this document electronically. You agree your electronic signature is the legal equivalent of your manual/handwritten signature on this document. By selecting "I Accept" using any device, means or action, you consent to the legally binding terms and conditions of this document. You further agree that your signature on this document (hereafter referred to as your "E-Signature") is as valid as if you signed the document in writing. You also agree that no certification authority or other third party verification is necessary to validate your E-Signature, and that the lack of such certification or third party verification will not in any way affect the enforceability of your E-Signature or any resulting document between you and BlueCross BlueShield of South Carolina.

E-Signature: _____

SC DOI License # _____

NPN: _____

Date: _____

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BlueCross BlueShield of South Carolina and
BlueChoice HealthPlan of South Carolina

Independent licensees of the Blue Cross and Blue Shield Association

PRODUCER APPOINTMENT AGREEMENT

☐ **BlueCross BlueShield of South Carolina** ☐ **BlueChoice HealthPlan**

☐ **Companion Life** - Life insurance is offered by Companion Life. Because Companion Life Is a separate company from BlueCross and BlueChoice HealthPlan, Companion Life will be responsible for all services related to life insurance.

An Agreement between

BlueCross and BlueShield of South Carolina, BlueChoice HealthPlan and Companion Life Insurance Company and its family of companies (hereinafter referred to as the "Companies"), and _____ (hereinafter referred to as the "Producer").
(Print Producer's Name)

You are requested to make application to the South Carolina Department of Insurance for the appointment authorizing you to solicit applications on behalf of the Companies.

I hereby agree that your consent to the appointment is subject to, and I hereby agree to be bound by, each and all of the following conditions:

(1) That I will be a producer assigned to, and under the jurisdiction of the Companies.
(2) That I will be expected to act in the best interests of the Companies.
(3) That I am not, and I will refrain from holding myself out as, an employee, partner, joint venturer or associate of the Companies.
(4) That I will comply with the rules, regulations and rate books of the Companies, the laws of the state in which I am licensed, and the regulations of the Department of Insurance related to my activities in the solicitation of insurance. I understand that if I sell any Medicare-related products, the sale of these products is subject to the regulations set out by the Centers for Medicare & Medicaid Services, and all marketing I do is regulated by those regulations.
(5) That I will obtain or participate in all required training for any line of products prior to selling that product line.
(6) That I will not alter, modify, waive or change any of the terms, rates or conditions of any advertisements, receipts, policies or contracts of the Companies in any respect.
(7) That I will promptly remit to my General Agency or the Companies any and all monies or securities received by me, or on behalf of the Companies, as full or partial payment of the first year or renewal premiums, or any other item whatsoever, without setoff or reduction.
(8) That I will not obligate the Companies nor incur expenses in their behalf in any manner whatsoever.
(9) That the Companies may, without liability to me whatsoever, upon request of my General Agency or on its own initiative, cancel my appointment at any time. Companies also reserve the right, at any time, to terminate my commission payments, with or without cause.
(10) That I understand that any and all of the business written while I am under the jurisdiction of the General Agency shown below will remain with the Agency in the event I should terminate my contract with that General Agency, or in the event of my death.
(11) That I agree to maintain professional liability insurance for errors and omissions in the minimum amount of $1,000,000 and to provide proof of such insurance annually, or upon request.
(12) That I will provide the policy holder with adequate information regarding benefits and benefit changes to the policy, including conducting enrollment meetings at point of sale if requested by the Policyholder.
(13) That I will deliver policies and contracts and deliver renewal notifications in a timely manner, in accordance with South Carolina laws.
(14) That I will assist the Companies in servicing their products, and extend such other service to policyholders and their beneficiaries as is proper and customary under the Companies' rules and methods of operations.

Forms MUST be completed in their entirety, saved and emailed to Agent.Appointment@bcbssc.com.
For questions concerning Agent Appointments, please email Appointment.Inquiry@bcbssc.com.

(15) That to maintain my appointment to represent the Companies, I must produce and have issued a minimum of five (5) lives (group and/or individual) in a rolling 12-month period. Production will be reviewed quarterly.

(16) I expressly agree and understand the following in accordance with 45 C.F.R. § 156.340:

a. In the course of performing the duties and obligations required by this appointment, the undersigned Agent may constitute a "delegated entity," and may contract with other vendors who constitute "downstream entities," as such terms are defined in 45 C.F.R. § 156.20, to assist in performing duties and obligations required by this Certification.

b. I shall comply with all applicable laws and regulations, including but not limited to the provisions of 45 C.F.R. Parts 155 and 156, to the extent relevant, in the performing or assisting in the performance of the duties and obligations required by this Certification.

c. I shall grant access to its books, contracts, computers, or other electronic systems (including medical records and documentation), relating to Agent's compliance with applicable provisions under 45 C.F.R. Parts 155 and 156 in connection with the duties and obligations required by this Certification, to the U.S. Department of Health and Human Services (HHS) and its Office of Inspector General (or their designees), for the duration of the period of Agency's appointment pursuant to this Certification, and for a minimum of ten (10) years from the date Agency's appointment terminates.

d. I shall include in its contracts with any downstream entities, and require such downstream entities to include in their contracts with other downstream entities, language that is the same or substantially similar to that contained in this Section, and which expressly requires each downstream entity to:

   1. Comply with all applicable laws and regulations, including but not limited to the provisions of 45 C.F.R. Parts 155 and 156, to the extent relevant, in performing or assisting in the performance of the duties and obligations required by this Certification, and
   2. Grant access to its books, contracts, computers, or other electronic systems (including medical records and documentation), relating to such downstream entity's compliance with applicable provisions under 45 C.F.R. Parts 155 and 156 in connection with the duties and obligations required by this Certification, to HHS and its Office of Inspector General (or their designees), for the duration of the period of Agency's appointment pursuant to this Certification, and for a minimum of ten (10) years from the date Agency's appointment terminates.

e. Any contractor used by me shall furnish BlueCross with a copy of the pertinent contract language (including amendments thereto) between such contractor and any downstream entities, and among two or more downstream entities, as applicable, to demonstrate compliance with this entire Section. Such contract language (including amendments thereto) shall be furnished to BlueCross as soon as practicable following its adoption.

f. In the event that BlueCross or HHS determines that any contractor used by me, or any downstream entity with whom such contractor contracts, as described in this Section, has not performed satisfactorily the duties and obligations required by this Certification, BlueCross shall have the right to revoke such duties and obligations and terminate my appointment, upon providing thirty (30) days advance notice and an opportunity to cure, to the extent that BlueCross determines, in its sole discretion, that such advance notice and opportunity to cure are feasible and proper under the circumstances.

g. The provisions of this Section shall in no way be interpreted as an assumption by BlueCross of legal liability for the actions of any contractor used by myself or any downstream entities, including, but not limited to, malpractice or other liability.

I hereby expressly acknowledge that this Agreement constitutes a contract solely between me and Blue Cross and Blue Shield of South Carolina, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. The "Association" permits Blue Cross and Blue Shield of South Carolina to use the Blue Cross and Blue Shield service marks in the state of South Carolina, and Blue Cross and Blue Shield of South Carolina is not contracting as a Producer of the Association. I further acknowledge and agree that I have not entered into this agreement based upon representations by any person other than Blue Cross and Blue Shield of South Carolina. No third party shall be held liable or accountable to me for any of the Blue Cross and Blue Shield of South Carolina obligations created under this agreement. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of South Carolina other than those obligations created under other provisions of this Agreement. The Agreement is effective the day assigned by Blue Cross and Blue Shield of South Carolina.

I request an insurance appointment for the state of South Carolina.

☐ I Accept, Electronic Signature. By selecting "I Accept" you are signing this document electronically. You agree your electronic signature is the legal equivalent of your manual/handwritten signature on this document. By selecting "I Accept" using any device, means or action, you consent to the legally binding terms and conditions of this document. You further agree that your signature on this document (hereafter referred to as your "E-Signature") is as valid as if you signed the document in writing. You also agree that no

certification authority or other third party verification is necessary to validate your E-Signature, and that the lack of such certification or third party verification will not in any way affect the enforceability of your E-Signature or any resulting document between you and BlueCross BlueShield of South Carolina.

E-Signature:

SC DOI License #

NPN:

Date:

Agency Representative

The Applicant is recommended for appointment as a Producer assigned to my jurisdiction, subject to the terms of my Agency Agreement with the Companies and with this Agreement.

☐ I Accept, Electronic Signature**.** By selecting "I Accept" you are signing this document electronically. You agree your electronic signature is the legal equivalent of your manual/handwritten signature on this document. By selecting "I Accept" using any device, means or action, you consent to the legally binding terms and conditions of this document. You further agree that your signature on this document (hereafter referred to as your "E-Signature") is as valid as if you signed the document in writing. You also agree that no certification authority or other third party verification is necessary to validate your E-Signature, and that the lack of such certification or third party verification will not in any way affect the enforceability of your E-Signature or any resulting document between you and BlueCross BlueShield of South Carolina.

E-Signature:

Title:

Agency Name:

Agency SC DOI License #:

Date:

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

Print or type
See **Specific Instructions** on page 2.

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; 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. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member 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.)

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 Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number

or

Employer identification number

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); 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 on page 3.

Sign Here | **Signature of U.S. person** ▸ | **Date** ▸

General Instructions

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

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

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?* on page 2.

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?* on page 2 for further information.

Forms MUST be completed in their entirety, saved and emailed to Agent.Appointment@bcbssc.com.

For questions concerning Agent Appointments, please email Appointment.Inquiry@bcbssc.com.

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 Publication 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 28% 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 Part II instructions on page 3 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* on page 3 and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships* above.

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* on page 3 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, list first, and then circle, the name of the person or entity whose number you entered in Part I of 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.

Forms MUST be completed in their entirety, saved and emailed to Agent.Appointment@bcbssc.com.

For questions concerning Agent Appointments, please email Appointment.Inquiry@bcbssc.com.

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

Limited Liability Company (LLC). If the name on line 1 is an LLC treated as a partnership for U.S. federal tax purposes, check the "Limited Liability Company" box and enter "P" in the space provided. If the LLC has filed Form 8832 or 2553 to be taxed as a corporation, check the "Limited Liability Company" box and in the space provided enter "C" for C corporation or "S" for S corporation. If it is a single-member LLC that is a disregarded entity, do not check the "Limited Liability Company" box; instead check the first box in line 3 "Individual/sole proprietor or single-member LLC."

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space in 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.

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. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited Liability Company (LLC)* on this page), 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 the chart on page 4 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. You can get Forms W-7 and SS-4 from the IRS by visiting IRS.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

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.*

Forms MUST be completed in their entirety, saved and emailed to Agent.Appointment@bcbssc.com.

For questions concerning Agent Appointments, please email Appointment.Inquiry@bcbssc.com.

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 items 1, 4, or 5 below indicate 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), 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)	The actual owner of the account or, if combined funds, the first individual on the account[1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor[2]
4. a. The usual revocable savings trust (grantor is also trustee) b. So-called trust account that is not a legal or valid trust under state law	The grantor-trustee[1] The actual owner[1]
5. Sole proprietorship or disregarded entity owned by an individual	The owner[3]
6. 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:**
7. Disregarded entity not owned by an individual	The owner
8. A valid trust, estate, or pension trust	Legal entity[4]
9. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
10. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
11. Partnership or multi-member LLC	The partnership
12. A broker or registered nominee	The broker or nominee
13. 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
14. 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* on page 2.

***Note.** 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 Publication 4535, Identity Theft Prevention and Victim Assistance.

Victims of identity theft who are experiencing economic harm or a system 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 contact them at *www.ftc.gov/idtheft* or 1-877-IDTHEFT (1-877-438-4338).

Visit IRS.gov 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.

Forms MUST be completed in their entirety, saved and emailed to Agent.Appointment@bcbssc.com.

For questions concerning Agent Appointments, please email Appointment.Inquiry@bcbssc.com.

BlueCross BlueShield of South Carolina and
BlueChoice HealthPlan of South Carolina

Independent licensees of the Blue Cross and Blue Shield Association

COMMISSION ASSIGNMENT AGREEMENT

☐ **BlueCross BlueShield of South Carolina** ☐ **BlueChoice HealthPlan**

☐ **Companion Life** - Life insurance is offered by Companion Life. Because Companion Life Is a separate company from BlueCross and BlueChoice HealthPlan, Companion Life will be responsible for all services related to life insurance.

I, (Print Name) _____ hereby agree that my appointment is subject to, and I hereby agree to be bound by, the following conditions:

(1) I understand that all business written while under the jurisdiction of the General Agency who requested my appointment (see below) belongs to the Agency in the event I terminate my contract with that Agency.

(2) I understand that at any time, either while I am under the jurisdiction of the General Agency or after that relationship has ended, the General Agency may change payment of the commissions to the Agency.

(3) This Commission Assignment cannot be revoked, except with the express approval of the General Agency shown below. If I wish to change the method of paying commissions for business written while under this appointment, I will be required to submit a new Commission Assignment form, signed by myself and the General Agency through which I have been appointed.

(4) That Companies have no obligation to me for expenses or any form of compensation whatsoever in connection with the services performed and expenses incurred by me in the solicitation of applications for insurance by the Companies.

(5) That Companies reserves the right to recover overpayments from future commission payments. In the event an error is made in the calculation and/or payment of commissions under this Agreement, regardless of who made the error or the reason for the error, parties agree that correction of the error shall be made retroactively for a maximum of twelve (12) months from the date the error was discovered by Companies.

(6) Upon termination of my appointment, Companies reserves the right to cease paying any additional commissions regardless of the date a policy or contract was written.

Please check the appropriate box below to indicate your choice of commission payment and complete only the section following your choice.

☐ Pay commissions directly to the Agency.

(1) I request that all commissions paid as a result of business I write be paid directly to the Agency through which I have been appointed, as evidenced by the signature of the Agency on the preceding page and below.

(2) That because I have assigned my commissions directly to the Agency, Companies has no obligation to me for commissions or any form of compensation whatsoever in connection with business I have written.

(3) All commissions earned while under this Commission Assignment will continue to be paid to the Agency as long as the contracts or policies remain in force and subject to commission payments.

☐ Pay commissions directly to the Producer.

I request that commissions paid as a result of business I write be paid directly to me.

☐ Pay commissions to a third party (neither Producer nor Agency).

I request that commissions paid as a result of business I write be paid to:

_____

Forms MUST be completed in their entirety, saved and emailed to Agent.Appointment@bcbssc.com.
For questions concerning Agent Appointments, please email Appointment.Inquiry@bcbssc.com.

BlueCross BlueShield of South Carolina and
BlueChoice HealthPlan of South Carolina

Independent licensees of the Blue Cross and Blue Shield Association

COMMISSION ASSIGNMENT AGREEMENT

☐ **BlueCros** **lueChoice HealthPlan** ☐ **Companion Life***

Life insurance is of **n Life is solely responsible for all services related to life insurance.*

I, (Prin ereby agree that my appointment is subject to, and I hereby agree to be bound by, the follow

(1) I understand that all business written while under the jurisdiction of the Agency who requested my appointment (see below) belongs to the Agency in the event I terminate my contract with that Agency.

(2) If I wish to change the method of paying commissions for business written while under this appointment, I will be required to submit a new Commission Assignment form, signed by myself and the Agency through which I have been appointed.

(3) That the Companies have no obligation to me for expenses or any form of compensation whatsoever in connection with the services performed and expenses incurred by me in the solicitation of applications for insurance by the Companies.

(4) That Companies reserve the right to recover overpayments from future commission payments. In the event an error is made in the calculation and/or payment of commissions under this Agreement, regardless of who made the error or the reason for the error, parties agree that correction of the error shall be made retroactively for a maximum of twelve (12) months from the date the error was discovered by Companies.

(5) Upon termination of my appointment, Companies reserves the right to cease paying any additional commissions regardless of the date a polic

Please select fr ns payment(s):

☐ Pay commissions directly t

(t of business I write be paid directly to the Agency through which I have been appointed, as evidenced by the signature of the Agency on the preceding page and below.

(2) That because I have assigned my commissions directly to the Agency, Companies has no obligation to me for commissions or any form of compensation whatsoever in connection with business I have written.

(3) All commissions earned while under this Commission Assignment will continue to be paid to the Agency as long as the contracts or policies remain in force and subject to commission payments.

☐ Pay commissions directly to Producer (must select 1 or 2).

(1) ☐ I request that commissions paid as a result of **all** business I write be paid directly to me; this includes **Medicare Advantage** business.

(2) ☐ I request that commissions paid as a result of **Medicare Advantage** business I write be paid directly to me (must select a or b).

a. ☐ I am a newly appointed agent with the Companies and request that commissions paid as a result of the all other lines of business be paid (must select 1 or 2).

1. ☐ Pay commissions directly to the Agency; conditions outlined above apply.
2. ☐ Pay commissions to a third party (neither Producer nor Agency).

b. ☐ I am currently appointed with the Companies, Agent ID_____, and request that commissions paid as a result of all other lines of business be paid in accordance with the Commission Assignment Agreement on file with the Companies.

☐ Pay commissions to a third party (neither Producer nor Agency).

I request that commissions paid as a result of business I write be paid to:_____

_____

IN WITNESS WHEREOF, Companies, Agent and Agency execute this to be effective on the last date written below.

Agent:

Signature: _____

SCDOI License #_____

NPN:_____

Date:_____

Agency Representative:

As the representative for the Agency of which this producer is requesting appointment, I agree to accept the Commission Assignment as indicated above.

Signature: _____

Name: _____

Title:_____

Agency Name:_____

Date:_____

Company Representatives:

Blue Cross and Blue Shield of South Carolina	BlueChoice HealthPlan of South Carolina, Inc.	Companion Life Insurance Company
By: Stephanie L. DeFreese	By:	By:
Name: Stephanie DeFreese		
Title: Vice President, Agency Sales	Title: Vice President, Sales	Title: Vice President, Field Marketing
Date:	Date:	Date:

AGREEMENT WITH BUSINESS ASSOCIATE

This Agreement ("BAA") is effective upon execution, and is made by and between the undersigned Agent/Agency ("Business Associate") and BlueCross and BlueShield of South Carolina ("BlueCross") and BlueChoice HealthPlan of South Carolina Inc. ("BlueChoice"), both independent licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans hereafter collectively referred to as "Company".

Company and Business Associate mutually agree to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations (45 C.F.R. Parts 160-64) and the requirements of the Health Information Technology for Economic and Clinical Health Act, as incorporates in the American Recovery and Reinvestment Act of 2009 (the "HITECH Act"), that are applicable to business associates, along with any guidance and/or regulations issued by DHHS. Company and Business Associate agree to incorporate into this Agreement any regulations issued with respect to the HITECH Act that relate to the obligations of business associates. Business Associate recognizes and agrees that it is obligated by law to meet the applicable provisions of the HITECH Act.

A. Privacy & Security of Protected Health Information and Electronic Protected Health Information.

1. Permitted Uses and Disclosures. Business Associate is permitted or required to use or disclose Protected Health Information ("PHI") and electronic PHI it creates or receives for or from Company or to request PHI and electronic PHI on Company's behalf only as follows:

a) Functions and Activities on Company's Behalf. To perform functions, activities, services, and operations on behalf of Company, consistent with HIPAA, the HITECH Act, and their implementing regulations as specified in the Agent/Agency Agreement.

b) Business Associate's Operations. Business Associate may use the Minimum Necessary PHI and electronic PHI for Business Associate's proper management and administration or to carry out Business Associate's legal responsibilities. Business Associate may disclose the Minimum Necessary PHI and electronic PHI for Business Associate's proper management and administration or to carry out Business Associate's legal responsibilities only if:

(i) The disclosure is required by law; or

(ii) Business Associate obtains reasonable assurance, evidenced by written contract, from any person or organization to which Business Associate will disclose PHI or electronic PHI that the person or organization will:

a. Hold such PHI, electronic PHI in confidence and use or further disclose it only for the purpose for which Business Associate disclosed it to the person or organization or as Required by Law; and

b. Promptly notify Business Associate (who will in turn promptly notify Company) of any instance of which the person or organization becomes aware in which the confidentiality of such PHI or electronic PHI was breached.

2. Minimum Necessary and Limited Data Set. Business Associate's use, disclosure or request of Protected Health Information shall utilize a Limited Data Set if practicable. Otherwise, Business Associate will, in its performance of the functions, activities, services, and operations specified in Section A.1(a) above, make reasonable efforts to use, to disclose, and to request of a Covered Entity only the minimum amount of Company's Protected Health Information reasonably necessary to accomplish the intended purpose of the use, disclosure or request. In addition, Business Associate also agrees to implement and follow appropriate minimum necessary policies as prescribed by any guidance issued by the United States Department of Health and Human Services.

3. **Prohibition on Unauthorized Use or Disclosure.** Business Associate will neither use nor disclose PHI or electronic PHI except as permitted or required by this Agreement, as otherwise permitted in writing by Company, or as required by law. This Agreement does not authorize Business Associate to use or disclose PHI or electronic PHI in a manner that would violate the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. Parts 160-64) or the HITECH Act and its implementing regulations, if done by Company, except as set forth in Section A(1)(b).

4. **Sale of PHI:** Business Associate shall not directly or indirectly receive remuneration in exchange for PHI except where permitted by the Agreement and consistent with applicable law.

5. **Marketing:** Business Associate shall not directly or indirectly receive payment for any use or disclosure of PHI for marketing purposes except where permitted by the Agreement and consistent with applicable law.

6. **Fundraising:** Business Associate shall not use or disclose PHI for fundraising purposes except where permitted by the Agreement and consistent with applicable law.

7. **Genetic Information:** Business Associate shall not use or disclose genetic information to the extent prohibited by 45 C.F.R § 164.502(a)(5)(i).

8. To the extent that Company and Business Associate agree that Business Associate is to carry out Company's or its clients' obligations under 45 C.F.R. Part 164, Subpart E (the Privacy Rule), Business Associate shall comply with the requirements of the Privacy Rule that apply to Company or its clients in the performance of such obligation. In addition, Business Associate shall comply with the applicable requirements of 45 C.F.R. Part 164, Subpart C. This provision shall not be interpreted to limit the generality of any other provision of this Agreement.

9. **Information Safeguards.** Business Associate will develop, document, implement, maintain, and use appropriate administrative, technical, and physical safeguards, in compliance with Social Security Act § 1173(d) (42 U.S.C. § 1320d-2(d)), 45 C.F.R. Part 164, Subparts A, C, D, & E, and any other implementing regulations issued by the U.S. Department of Health and Human Services (including, but not limited to, the Acceptable Risk Safeguards, to the extent applicable (https://www.cms.gov/InformationSecurity/14_Standards.asp), and any other applicable laws requiring information safeguards, including, but not limited to, applicable state law and applicable requirements of the Defense Health Agency. The safeguards will be designed to preserve the integrity, availability and confidentiality of electronic PHI, and to prevent intentional or unintentional non-permitted or violating use or disclosure of, PHI. Business Associate will additionally develop any safeguards to the extent required by the HITECH Act. Business Associate will document and keep these safeguards current. Business Associate agrees to mitigate any harmful effect that is known to the Business Associate resulting from a use or disclosure of PHI or electronic PHI by the Business Associate or its subcontractors in violation of the requirements of this Agreement. Business Associate shall also develop and implement written policies and procedures to meet the relevant documentation requirements of the Privacy, Security, and Breach Notification Rules (45 C.F.R. Part 164, Subparts A, C, D, & E).

10. **Subcontractors and Agents.** Business Associate will require any of its subcontractors and agents, to which Business Associate is permitted by this Agreement or in writing by Company to disclose PHI and electronic PHI, to provide reasonable assurance, evidenced by written contract, that such subcontractor or agent will comply with the same privacy, security, and breach notification obligations as Business Associate with respect to such PHI and, electronic PHI.

B. **Compliance with Standard Transactions.** If Business Associate conducts, in whole or part, Standard Transactions for or on behalf of Company, Business Associate will comply, and will require any subcontractor or agent involved with the conduct of such Standard Transactions to comply, with each applicable requirement of 45 C.F.R. Part 162. Business Associate will not enter into, or permit its subcontractors or agents to enter into, any

Trading Partner Agreement in connection with the conduct of Standard Transactions for or on behalf of Company that:

1. Changes the definition, data condition, or use of a data element or segment in a Standard Transaction;

2. Adds any data element or segment to the maximum defined data set;

3. Uses any code or data element that is marked "not used" in the Standard Transaction's implementation specification or is not in the Standard Transaction's implementation specification; or

4. Changes the meaning or intent of the Standard Transaction's implementation specification.

C. Individual Rights.

1. Access. Business Associate will, within five (5) business days after Company's request, make available to Company or, at Company's direction, to the individual (or the individual's personal representative) for inspection and obtaining copies any PHI and electronic PHI about the individual that is in Business Associate's custody or control, so that Company may meet its access obligations under 45 C.F.R. § 164.524 and, where applicable, the HITECH Act. Business Associate shall make such information available in an electronic format where directed by Company.

2. Amendment. Business Associate will, upon receipt of notice from Company, promptly amend or permit Company access to amend any portion of the PHI and electronic PHI, so that Company may meet its amendment obligations under 45 C.F.R. § 164.526.

3. Disclosure Accounting. So that Company may meet its disclosure accounting obligations under 45 C.F.R. § 164.528:

a) Disclosure Tracking. Business Associate will record information concerning each disclosure of PHI or electronic PHI, not excepted from disclosure tracking under Agreement Section C.3(b) below, that Business Associate makes to Company or a third party. The Disclosure Information Business Associate will record includes the requirements set forth in the HIPAA Privacy Rule and the HITECH Act and relevant implementing regulations, including, but not limited to: (i) the disclosure date; (ii) the name and (if known) address of the person or entity to whom Business Associate made the disclosure; (iii) a brief description of the PHI or electronic PHI disclosed; and (iv) a brief statement of the purpose of the disclosure (items i-iv, collectively, the "disclosure information"). For repetitive disclosures Business Associate makes to the same person or entity for a single purpose, Business Associate may provide (x) the disclosure information for the first of these repetitive disclosures; (y) the frequency, periodicity or number of these repetitive disclosures; and (z) the date of the last of these repetitive disclosures.

Business Associate will make this disclosure information available to Company within ten (10) business days after Company's request.

b) Exceptions from Disclosure Tracking. Business Associate need not record disclosure information or otherwise account for disclosures of PHI or electronic PHI that this Agreement or Company in writing permits or requires (i) for purposes of Treating the individual who is the subject of the PHI or electronic PHI disclosed, payment for that Treatment, or for the Health Care Operations of Company or Business Associate (except where such recording or accounting is required by the HITECH Act, and as of the effective dates for this provision of the HITECH Act); (ii) to the individual who is the subject of the PHI or electronic PHI disclosed or to that individual's personal representative; (iii) pursuant to a valid authorization by the person who is the subject of the PHI or electronic PHI disclosed; (iv) to persons involved in that individual's health care or Payment related to that individual's health care; (v) for notification for disaster relief

purposes; (vi) for national security or intelligence purposes; (vii) as part of a Limited Data Set; or (viii) to law enforcement officials or correctional institutions regarding inmates or other persons in lawful custody.

c) Disclosure Tracking Time Periods. Unless otherwise provided under the HITECH Act, Business Associate must have available for Company the disclosure information required by Agreement Section C.3(a) for the six (6) years preceding Company's request for the disclosure information. In addition, where Business Associate is contacted directly by an individual based on information provided to the individual by Company, and where so required by the HITECH Act and/or any accompanying regulations, Business Associate shall make such Disclosure Information available directly to the individual.

4. Restriction Requests; Confidential Communications. Business Associate shall immediately notify Company's Privacy Officer of any individual request made pursuant to 45 C.F.R. § 164.522 that Company or Business Associate restrict the disclosure of protected health information of the individual. Business Associate will comply with any requests for restriction requests and confidential communications of which it is aware and to which Company agrees pursuant to 45 C.F.R. § 164.522 (a) and (b).

5. Inspection of Books and Records. Business Associate will make its internal practices, books, and records, relating to its use and disclosure of PHI or electronic PHI, available to Company and to the U.S. Department of Health and Human Services to determine compliance with 45 C.F.R. Parts 160-64 or this Agreement. In addition, beginning January 1, 2017, Business Associate shall, upon Company's request, provide either: (a) a copy of a SOC 2, Type 2 report or a certification that the ISO 27001:2013 or HITRUST standards have been met that has been issued within the last 12 months prior to the request; or (b) an equivalent report, in Company's sole discretion, that attests to the sufficiency of Business Associate's physical, technical, and administrative controls on the privacy and security of Protected Health Information in a form provided by Company that has been signed within the last 12 months prior to the request.

D. Breach of Privacy & Security Obligations.

1. Breach. . Except to the extent provided otherwise in Subsection D.2(b) below (providing an immediate reporting time frame, but in no case longer than 60 minutes for suspected or actual improper uses, accesses, or disclosures of protected health information of Regular Medicare or TRICARE Beneficiaries)Business Associate will report to Company any use or disclosure of PHI or electronic PHI not permitted by this Agreement or by Company in writing. Business Associate will make the report to Company's Privacy Officer within three (3) business days after Business Associate knew or by the exercise of reasonable diligence should have known of such non-permitted use or disclosure. In addition, Business Associate will report, following discovery and without unreasonable delay, but in no event later than three (3) business days following discovery, any "Breach" of "Unsecured Protected Health Information" as these terms are defined by the HITECH Act and any implementing regulations, even if Business Associate deems the unauthorized acquisition, access or use to be in good faith, unintentional or inadvertent and even if Business Associate deems the risk that PHI has been compromised to be low. Business Associate shall cooperate with Company in investigating the Breach and in meeting the Company's obligations under the Breach Notification Regulations (45 C.F.R. Part 164, Subparts A, D) and any other security breach notification laws.

Any such report shall include the identification (if known) of each individual whose Unsecured Protected Health Information has been, or is reasonably believed by Business Associate to have been, accessed, acquired, or disclosed during such Breach. Business Associate's report will, at a minimum:

a) Identify the nature of the non-permitted access, use or disclosure, including the date of the Breach and the date of discovery of the Breach;

b) Identify the PHI or electronic PHI accessed, used or disclosed as part of the Breach (e.g. full name, social security number, date of birth, etc.);

c) Identify who made the non-permitted or violating access, use or disclosure and who received the non-permitted disclosure;

d) Identify what corrective action Business Associate took or will take to prevent further non-permitted access, uses or disclosures;

e) Identify what Business Associate did or will do to mitigate any deleterious effect of the non-permitted access, use or disclosure; and

f) Provide such other information, including a written report, as Company may reasonably request.

2. **Security Incident**. (a) Business Associate will report to Company any attempted or successful (a) unauthorized access, use, disclosure, modification, or destruction of Company's electronic PHI of which Business Associate becomes aware, or (b) any interference with system operations in Business Associate's Information System containing Company's electronic PHI ("Security Incident") of which Business Associate becomes aware. Business Associate will make this report upon Company's request, except if any such Security Incident resulted in an unauthorized access, use, or disclosure of Company's electronic PHI not permitted by this Agreement. If the Security Incident resulted in an unauthorized access, use, or disclosure, then a written report shall be provided according to the timeline and content requirements in Section D.1 above.

Business Associate understands that some of the data it will Use, Disclose or have access to may be data of Medicare beneficiaries. In the event that Business Associate Uses, Discloses, or has access to data of Medicare beneficiaries other than Medicare Advantage beneficiaries ("Regular Medicare Beneficiaries") or TRICARE beneficiaries, Business Associate understands that, with respect to PHI, as defined in the above recitals, Company has a higher duty to report security incidents, as defined below, than with commercial beneficiaries. As a result, Business Associate agrees to report any security incidents involving PHI of Regular Medicare Beneficiaries or TRICARE beneficiaries immediately upon and in no case longer than sixty (60) minutes of discovery of such incident or otherwise, so that Company will have a reasonable amount of time to report said security incident to the Center for Medicare and Medicaid Services (CMS) or the Defense Health Agency (DHA), according to the deadlines set forth by CMS or DHA. Business Associate agrees to provide promptly any information related to such security incident or Business Associate's response to such incident that Company shall reasonably request. Business Associate understands and agrees that security incidents, as used in this subsection D.2(b) shall mean the following:

A security incident is the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system. It also means the loss of data through theft or device misplacement, loss or misplacement of hardcopy documents and misrouting of mail, all of which may have the potential to put the data at risk of unauthorized access, use, disclosure, modification, or destruction.

3. **Mitigation**. Business Associate agrees to mitigate, to the extent practicable, any harmful effect resulting from any Breach or attempted or successful Security Incident. In addition, Business Associate shall cooperate with and implement any reasonable mitigation requests by Company relating to any Breach or attempted or successful Security Incident. Any mitigation performed pursuant to this Section shall be done at Business Associate's expense.

E. **General Provisions.**

1. **Termination of Agreement.**

a) Right to Terminate for Breach.

(i). Company may terminate Agreement if it determines, in its sole discretion, that Business Associate has breached any provision of this Agreement. Company may exercise this right to terminate Agreement by providing Business Associate written notice of termination, stating the breach of the Agreement that provides the basis for the termination. Any such termination will be effective immediately or at such other date specified in Company's notice of termination.

(ii). Business Associate may terminate Agreement if it determines, after reasonable consulting with Company, that Company has breached any material provision of this Agreement and upon written notice to Company of the breach, Company fails to cure the breach within thirty (30) days after receipt of the notice. Business Associate may exercise this right to terminate Agreement by providing Company written notice of termination, stating the failure to cure the breach of this Agreement that provides the basis for the termination. Any such termination will be effective upon such reasonable date as the parties mutually agree.

b) Obligations upon Termination.

(i) Return or Destruction. Upon termination, cancellation, expiration or other conclusion of Agreement, Business Associate will, if feasible, return to Company or destroy all PHI and electronic PHI in whatever form or medium (including any electronic medium) and all copies of any data or compilations derived from and allowing identification of any individual who is a subject of PHI and electronic PHI. Company will determine, in its sole discretion, whether Business Associate will destroy or return such PHI and electronic PHI. Business Associate will complete such return or destruction as promptly as possible, but not later than ten (10) business days after the effective date of the termination, cancellation, expiration or other conclusion of Agreement. All costs related to the Business Associate's return or destruction of PHI and electronic PHI will be paid by the Business Associate. Business Associate will identify any PHI and electronic PHI that cannot feasibly be returned to Company or destroyed. Business Associate will limit its further use or disclosure of that PHI and electronic PHI to those purposes that make return or destruction of that PHI and electronic PHI infeasible. Within ten (10) business days after the effective date of the termination, cancellation, expiration or other conclusion of Agreement, Business Associate will (a) certify on oath in writing to Company that such return or destruction has been completed, (b) deliver to Company the identification of any PHI and electronic PHI for which return or destruction is infeasible, and (c) certify that it will only use or disclose such PHI and electronic PHI for those purposes that make return or destruction infeasible.

(ii) Continuing Privacy Obligation. Business Associate's obligation to protect the privacy of the PHI and electronic PHI it created or received for or from Company will be continuous and survive termination, cancellation, expiration or other conclusion of Agreement.

c) Other Obligations and Rights. Business Associate's other obligations and rights and Company's obligations and rights upon termination, cancellation, expiration or other conclusion of Agreement will be those set out in the Agreement.

2. Indemnity. Business Associate will indemnify and hold harmless Company and any Company affiliate, officer, director, employee or agent from and against any claim, cause of action, liability, damage, cost or expense, including attorneys' fees and court or proceeding costs, arising out of or in connection with any non-permitted or violating use or disclosure of PHI and electronic PHI or other breach of this Agreement by Business Associate or any subcontractor, agent, person or entity under Business Associate's control.

a) Right to Tender or Undertake Defense. If Company is named a party in any judicial, administrative or other proceeding arising out of or in connection with any non-permitted or violating use or disclosure of PHI and electronic PHI or other breach of this Agreement by Business Associate or any subcontractor, agent, person or entity under Business Associate's control, Company will have the option at any time to either: (i) tender its defense to Business Associate, in which case Business Associate will provide qualified attorneys, consultants, and other appropriate professionals to represent Company's interests at Business Associate's expense, or (ii) undertake its own defense, choosing the attorneys, consultants, and other appropriate professionals to represent its interests, in which case Business Associate will be responsible for and pay the reasonable fees and expenses of such attorneys, consultants, and other professionals.

b) Right to Control Resolution. Company will have the sole right and discretion to settle, compromise or otherwise resolve any and all claims, causes of actions, liabilities or damages against it, notwithstanding that Company may have tendered its defense to Business Associate. Any such resolution will not relieve Business Associate of its obligation to indemnify Company under this Agreement Section E.2.

3. Definitions. With respect to any information created, received, maintained, or transmitted by Business Associate from or on behalf of Company or another business associate of Company ("Company Information"), the following definitions apply:

a) The capitalized terms "Covered Entity," "Electronic Protected Health Information ("electronic PHI" or "ePHI" shall be construed to be "Electronic Protected Health Information"), "Protected Health Information" ("PHI" shall be construed to be "Protected Health Information"), "Standard," "Trading Partner Agreement," and "Transaction" have the meanings set out in 45 C.F.R. § 160.103.

b) The term "Standard Transactions" shall have the meaning set out in 45 C.F.R. § 162.103. The term "Minimum Necessary" shall have the meaning set out in 45 C.F.R. § 164.502.

c) The term "Required by Law" has the meaning set out in 45 C.F.R. § 164.103.

d) The terms "Health Care Operations," "Payment," "Research," and "Treatment" have the meanings set out in 45 C.F.R. § 164.501.

e) The term "Limited Data Set" has the meaning set out in 45 C.F.R. § 164.514(e). The term "use" means, with respect to PHI, utilization, employment, examination, analysis or application within Business Associate.

f) The terms "disclose" and "disclosure" mean, with respect to PHI, release, transfer, providing access to or divulging to a person or entity not within Business Associate.

g) Any other capitalized terms not identified here shall have the meaning as set forth in 45 Code of Federal Regulations ("C.F.R.") Parts 160-64 for the Administrative Simplification provisions of Title II, Subtitle F of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), or in the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 (the "HITECH Act").

4. Owner of Protected Health Information. Company is the exclusive owner of PHI and electronic PHI generated or used under the terms of the Agreement or this Agreement.

5. Amendment to Agreement. Upon the effective date of any final regulation or amendment to final regulations promulgated by the U.S. Department of Health and Human Services with respect to PHI, electronic PHI or Standard Transactions, this Agreement will automatically amend such that the obligations they impose on Business Associate remain in compliance with these regulations.

6. **Disclosure of De-identified Data**. The process of converting PHI or electronic PHI to De-identified Data ("DID") is set forth in 45 C.F.R. § 164.514. In the event that Company provides Business Associate with DID, Business Associate shall not be given access to, nor shall Business Associate attempt to develop on its own, any keys or codes that can be used to re-identify data.

7. **Creation of De-identified Data**. In the event Business Associate wishes to convert PHI or electronic PHI to DID, it must first subject its proposed plan for accomplishing the conversion to Company for Company's approval, which shall not be unreasonably withheld.

8. **Intent**. The parties agree that there are no intended third party beneficiaries under this Agreement.

IN WITNESS WHEREOF, Company and Business Associate execute this Agreement in multiple originals to be effective on the last date written below.

☐ I Accept, Electronic Signature**.** By selecting "I Accept" you are signing this document electronically. You agree your electronic signature is the legal equivalent of your manual/handwritten signature on this document. By selecting "I Accept" using any device, means or action, you consent to the legally binding terms and conditions of this document. You further agree that your signature on this document (hereafter referred to as your "E-Signature") is as valid as if you signed the document in writing. You also agree that no certification authority or other third party verification is necessary to validate your E-Signature, and that the lack of such certification or third party verification will not in any way affect the enforceability of your E-Signature or any resulting document between you and BlueCross BlueShield of South Carolina.

Agent / Agency Representative	**Blue Cross and Blue Shield of South Carolina**
E-Signature:	By: Stephanie L. DeFreese
Title:	Name: Stephanie DeFreese
Agent/Agency SCDOI #:	Title: Vice President, Agency Sales
Date:	Date: 01/18/2017

BlueChoice HealthPlan of South Carolina, Inc.
By:
Name: David Gwin
Title: Vice President, Sales
Date: 07/06/2017

Agency Only, Name and Address:

Forms MUST be completed in their entirety, saved and emailed to Agent.Appointment@bcbssc.com.
For questions concerning Agent Appointments, please email Appointment.Inquiry@bcbssc.com.

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BlueChoice HealthPlan of South Carolina

Independent licensees of the Blue Cross and Blue Shield Association

AGENCY AGREEMENT

☐ **BlueCross BlueShield of South Carolina** ☐ **BlueChoice HealthPlan**

☐ **Companion Life -** Life insurance is offered by Companion Life. Because Companion Life Is a separate company from BlueCross and BlueChoice HealthPlan, Companion Life will be responsible for all services related to life insurance.

This Agreement is made and entered into between BlueCross and BlueShield of South Carolina, Companion Life Insurance Company and BlueChoice HealthPlan and its family of companies (hereinafter referred to as the "Companies"), corporations organized under the laws of the state of South Carolina and having their principal place of business at I-20 East at Alpine Road, Columbia, South Carolina 29219 and

AGENCY NAME

Hereinafter referred to as the "Agency", having its principal place of business at:

Throughout this Agreement, Agency is understood to mean all persons associated with Agency, including its owners, partners, shareholders, employees and Producers or sub-agents.

I. RESPONSIBILITIES OF THE COMPANIES

In consideration of the Agreements set forth here, Companies grant to Agency the authority and power to solicit applications for insurance with Companies subject to the terms, conditions and limits set forth herein.

The authorization granted to Agency is limited to the territory in which Agency and Companies are properly licensed and authorized to carry out the transactions contemplated. This authority shall be non-exclusive.

II. DUTIES

The Agency shall act in the best interests of the Companies, its successors or assigns consumers. Subject to the terms and limitations of this Agreement, Agency agrees to:

1. Solicit and procure applications for life, accident and health, and disability insurance, as authorized by Companies.
2. Deliver policies, assist Companies in servicing its products, and extend such other service to policyholders and their beneficiaries as is proper and customary under Companies' rules and methods of operations.
3. Contract with persons licensed as Producers in South Carolina and, with the Companies' approval, request appointment of these Producers as sub-agents. Where appointment is made through Companies, all commissions will be payable to Agency unless specifically requested by Producer and agreed by Agency. Where compensation is paid through Agency, Producers shall have no claim against the Companies for commissions, salaries, or any other remuneration and all compensation to Producers and sub-agents will be the responsibility of Agency. It is solely the responsibility of the Agency to provide information to Producers concerning the conditions and manner of compensation and to clarify the relationship between itself and its owners, partners, Producers or sub-agents, and employees. Agency will be responsible for all expenses incurred by Agency in connection with activities pursuant to this Agreement, including licensing fees, salaries, travel expenses, benefits, any income or excise taxes, commissions and any and all other

expenses of such Producers. Agency agrees, however, that all Producers shall be subject to all the rules, restrictions and regulations set forth in this Agreement, which are applicable to Agency.
4. Deliver renewal notifications in a timely manner, in accordance with South Carolina laws.
5. Provide the policyholder with adequate information regarding benefits and benefit changes to the policy, including conducting enrollment meetings at point of sale if requested by the Policyholder.

III. RESPONSIBILITIES OF THE AGENCY
It is understood and agreed that Agency will:

1. Be governed by all rules, regulations and instructions of the Companies, together with the insurance laws and regulations of the state of South Carolina, and any other applicable laws;
2. Treat all money received and collected by Agency for Companies as property held in trust and remit such collections to Companies in accordance with its procedures;
3. Account for all policies, receipts, papers, records and property received by Agency from Companies, its policyholders and representatives;
4. Aid in the care and conservation of Companies' business and provide prompt service to policyholders;
5. Indemnify and hold Company harmless from any losses, damages, costs and liabilities suffered or incurred by Companies which may be caused by acts, negligence or dishonesty of the Agency, its owners, partners, Producers or sub-agents, contractors, or employees, including breaches of the Business Associate Agreement;
6. At all times during the term of this Agreement:
    a. Keep in force, at Agency's own expense, Commercial General Liability Insurance with a limit of not less than $1,000,000 per occurrence and $2,000,000 in the aggregate for bodily injury and property damage to include personal injury and contractual liability coverage;
    b. Maintain, or require each Producer to maintain, Professional Liability (Errors and Omissions) Insurance for $1,000,000 per occurrence and in the aggregate; and
    c. Provide proof of the above insurance on an annual basis, or as requested by Companies, verifying these coverages and limits. Said policies may not be materially modified or cancelled except after thirty (30) days prior written notice to Companies.
    d. Require Agency's Errors and Omissions issuer to notify Companies at least 30 days prior to cancellation of that coverage or material modification of coverage.
7. If Agency, its owners, partners, Producers or sub-agents, and employees, choose to assist any member, beneficiary or group in the collecting or data entry of information required or requested by Companies, then Agency, its owners, partners, Producers or sub-agents, and employees will be deemed to be are acting on behalf of the member, beneficiary or group.
8. Any errors or omissions while acting on behalf of the member, beneficiary or group will be the sole liability of the Agency, its owners, partners, Producers or sub-agents, and employees.
9. The Agency and all subagents are required to sign and return the Business Associates Agreement provided by Companies. Agency understands and agrees that the Business Associate Agreement is specifically incorporated by reference into this Agency Agreement and Agency will ensure that all owners, partners, shareholders, employees, and Producers or sub-agents abide by the terms of that Agreement.

IV. AGENCY AS A DELEGATED ENTITY
Agency expressly agrees and understands the following in accordance with 45 C.F.R. § 156.340:

1. In the course of performing the duties and obligations required by this Certification, the undersigned Agency may constitute a "delegated entity," and may contract with other vendors who constitute "downstream entities," as such terms are defined in 45 C.F.R. § 156.20, to assist in performing duties and obligations required by this Certification.
2. Agency shall comply with all applicable laws and regulations, including but not limited to the provisions of 45 C.F.R. Parts 155 and 156, to the extent relevant, in the performing or assisting in the performance of the duties and obligations required by this Certification.
3. Agency shall grant access to its books, contracts, computers, or other electronic systems (including medical records and documentation), relating to Agent's compliance with applicable provisions under 45 C.F.R. Parts 155 and 156 in connection with the duties and obligations required by this Certification, to the U.S. Department of Health and Human Services ("HHS") and its Office of Inspector General (or their designees), for the duration of the period of Agency's appointment pursuant to this Certification, and for a minimum of ten (10) years from the date Agency's appointment terminates.

4. Agency shall include in its contracts with any downstream entities, and require such downstream entities to include in their contracts with other downstream entities, language that is the same or substantially similar to that contained in this Section, and which expressly requires each downstream entity to:

a. Comply with all applicable laws and regulations, including but not limited to the provisions of 45 C.F.R. Parts 155 and 156, to the extent relevant, in performing or assisting in the performance of the duties and obligations required by this Certification, and

b. Grant access to its books, contracts, computers, or other electronic systems (including medical records and documentation), relating to such downstream entity's compliance with applicable provisions under 45 C.F.R. Parts 155 and 156 in connection with the duties and obligations required by this Certification, to HHS and its Office of Inspector General (or their designees), for the duration of the period of Agency's appointment pursuant to this Certification, and for a minimum of ten (10) years from the date Agency's appointment terminates.

5. Any contractor used by Agency shall furnish BlueCross with a copy of the pertinent contract language (including amendments thereto) between such contractor and any downstream entities, and among two or more downstream entities, as applicable, to demonstrate compliance with this entire Section. Such contract language (including amendments thereto) shall be furnished to BlueCross as soon as practicable following its adoption.

6. In the event that BlueCross or HHS determines that any contractor used by Agency, or any downstream entity with whom such contractor contracts, as described in this Section, has not performed satisfactorily the duties and obligations required by this Certification, BlueCross shall have the right to revoke such duties and obligations and terminate Agency's appointment, upon providing thirty (30) days advance notice and an opportunity to cure, to the extent that BlueCross determines, in its sole discretion, that such advance notice and opportunity to cure are feasible and proper under the circumstances.

7. The provisions of this Section shall in no way be interpreted as an assumption by BlueCross of legal liability for the actions of any contractor used by Agency or any downstream entities, including, but not limited to, malpractice or other liability.

V. LIMITATIONS OF AUTHORITY

It is understood and agreed that Agency has no authority, implied or otherwise, to:

1. On behalf of Companies, bind or obligate Companies to provide insurance coverage to any person or group. Coverage shall be effective only upon acceptance by the Companies, who reserve the right to decline any application;
2. Make, alter or discharge any contract;
3. Waive forfeiture;
4. Extend the time for payment, or allow waiver, of any premium;
5. Obligate Companies for payment of any debts;
6. Issue any receipt of any kind except as authorized by Companies;
7. Accept any past due premium;
8. Commingle any monies or funds received or collected on behalf of an applicant for the Companies' insurance policies with any Agency funds, nor establish any bank account to hold such funds;
9. Submit applications to the Companies on behalf of other Producers, except as set forth herein. If Producer submits applications on another Producer's behalf, all commissions paid or payable by the Companies to Agency or its designees for that policy shall be forfeited. Among other remedies, Companies may cancel this Agreement and offset forfeited commission against other commissions payable to Agency or its designees. No Producer shall solicit insurance for the Companies until Companies have approved his or her appointment to represent the Companies. Agency shall be responsible to the Companies for all business done by or entrusted to persons appointed by the Agency. The provisions of this Section shall not be construed in such a way that Agency or its Producers shall be prohibited from submitting applications or business produced by Agency's bona fide employees, provided, however, that Agency's employees are properly licensed and appointed with the Companies to produce applications of the type submitted;
10. Institute any legal proceeding involving Companies in any manner;
11. Use to the detriment of the Companies, any information about the business of the Companies, which Agency has obtained due to Agency's association with the Companies. This is applicable for the term of this Agreement and for a period of three (3) years thereafter. Agency recognizes that a remedy at law for any breach or threatened breach by Agency of this Section will be inadequate by its nature, and Companies shall be entitled to injunctive and other appropriate remedies if Agency violates this section.
12. Companies may, at its sole discretion and without notice, specify or limit those products that the Agency may solicit.

VI. ASSIGNMENT

1. This Agreement and the payments accruing under it may not be assignable without Companies' prior written consent.
2. Any requests for transfers of this Agency Agreement must contain the following:

a. An explanation of the primary business reason for wanting to transfer the Agency Agreement, i.e., inability of Agency owner to continue business for reasons such as retirement, moving out-of-state, disability, etc.; and
b. The length of time that the proposed transferee has been doing business with the Companies.
c. At the request of the Companies and within Companies' sole discretion, the Agency to whom the business will be transferred must be able to demonstrate both its ability to sell and retain business through its history with the Companies, and to demonstrate that it will be able to adequately service the business it wishes to purchase.
d. The Agency, its owners, partners, shareholders, employees and Producers or sub-agents, must agree in writing to all the terms and conditions of this Agreement, as well as the Producer Appointment Agreement and the Commission Assignment Form.

3. In no event shall blocks of business be merged for purposes of increasing overrides.
4. The Companies reserve the right to cancel transferee's appointment to represent him or her, and to withhold commission payments, if they deem transferee is actively soliciting to place transferred business with another carrier.

VII. COMPENSATION

1. Companies retain the right to change the commission rates and structure, including all new and in-force business, with 30 days prior notification, and such modified or replaced schedule shall apply to all other policies in force following the effective date of such modification or replacement.
2. Agency shall receive commission (as defined in the Commission Schedule) in accordance with the terms and conditions of the Commission Schedule. The term "Commission Schedule" refers to that document created and maintained by the Companies that details the manner and amounts that an Agency will be paid for the sale of a particular product. In no event shall any commissions be paid to an Agency or Producer not licensed in the state of South Carolina or appointed with Companies.
3. Commissions shall be payable only for so long as the Insured maintains a policy with Companies and Agency remains the "Agent of Record" for the Insured. In the event a policy or contract is cancelled, Agency shall repay to the Companies, on demand, the full amount of commissions paid on premiums not received or refunded. Companies shall have the authority to recover overpayments from future commission payments.
4. In the event that an error is made in the calculation and/or payment of Compensation under this Agreement, regardless of who made the error or the reason for the error, the parties agree that the correction of the error shall be made retroactively for a maximum of twelve (12) months from the date the error was discovered by Companies. This section shall not limit in any way Companies' right to collect any indebtedness of Agency to Companies, through offset of compensation or otherwise, for reasons other than error in calculations or payments.
5. Termination of this Agreement for cause shall immediately void the Companies' obligations under this Section. Agency agrees to repay to the Companies any and all amounts paid by Companies to the Agency on any business for dates of service after the effective date of any such revocation, termination or cancellation. Agency's duties of indemnification and confidentiality will remain in force for a minimum term of three (3) years following termination of this Agreement, or for the maximum period of time allowed or required by law.
6. Agency agrees to fully disclose to his or her group clients, subscribers or applicants for insurance, all reportable compensation Agency receives from Companies to the extent and in the manner consistent with applicable federal or state laws, regulations and/or requirements or under any agreement with group clients, subscribers or applicants for insurance.
7. Companies may offset against any claim for compensation hereunder any debts or charges now due or which may become due Companies from Agency at any time. Such debts or charges shall be a first lien against any commissions due Agency under this Agreement. In the event commissions due Agency are insufficient to discharge Agency's indebtedness, the balance due, if any, shall be a debt which Agency hereby assumes and agrees to pay.
8. If a policy is cancelled by Companies at the request of the insured or applicant for any reason whatsoever, or if Companies rescinds a policy on the grounds of misrepresentation, Companies shall be the sole judge of Agency's commission interest in that policy.

VIII. AGENCY STATUS

1. This Agreement shall not be construed as creating the relationship of employer/employee between Companies and Agency. The relationship of Agency to the Companies is and shall be that of an independent contractor. Within the scope of Agency's authority, duties and responsibilities, Agency shall exercise independent judgment as to the persons from whom applications for insurance are solicited and the time, place and manner of such solicitation.
2. Agency understands and agrees that the purpose of extended or available training courses, sales methods and materials, prospects, leads, or similar aids and services shall assist Agency in the conduct of Agency's business, but is not intended to give Companies control over Agency's time, direction and manner, or means by which Agency shall conduct Agency's business.

3. If Agency sells Medicare-related products, Agency understands that the sale of these products is subject to regulations set out by the Centers for Medicare & Medicaid Services that all marketing is regulated by those regulations, and agrees to train or require training of all Producers or sub-agents supervised by Agency who engage in sales of these products.
4. Agency is neither required to devote full time to the performance of this Agreement nor perform the services personally. Agency is free to solicit business for other companies; however, other requirements may apply, including any other requirements listed in other appointment documents of the Companies, including the Producer Appointment Agreement and the Letter of Intent (if one has been signed).

IX. CONFLICT WITH LAW OR REGULATION

If, at any time, the provisions of this Agreement conflict with any law, regulation or ruling of any applicable governmental entity, the Agreement may be modified by Companies or by a court having competent jurisdiction, without Agency's consent, to comply with such law, regulation or ruling.

X. NON-WAIVER

Failure of Companies to insist upon strict compliance with any terms of this Agreement or procedural requirements of Companies shall not be construed as a waiver of any such terms or requirements. All terms and requirements shall continue in full force and effect.

XI. SUPERCEDES ANY PRIOR AGREEMENT

This is the entire Agreement (including any other attachments or addendums) between the Agency and the Companies. This Agreement supercedes, terminates, and otherwise renders null and void any and all previous agreements (including Agency agreements or, to the extent applicable, any Producer Agreements or letters of intent) and any and all prior representations and statements of Companies, whether written, oral or implied, and now constitutes the entire agreement between the parties as of the effective date of this Agreement. Notwithstanding the foregoing, this Agreement does not affect or waive claims of any kind which the Companies may have against the Agency under any previous contract.

XII. TERMINATION PROVISIONS

This Agreement is made subject to the following provisions with respect to termination and commissions after termination; this Agreement shall terminate:

1. At any time, by either party hereto, upon 30 days written notice.
2. In the event of the death of the sole proprietor or last remaining partner of the Agency.
3. By Companies for cause if, in Companies' opinion and at Companies' sole discretion, if Agency at any time:
    a. Perpetrates any fraud or commits any act of dishonesty upon an applicant, policyholder, beneficiary of Companies;
    b. Fails to promptly account for and pay to Companies money due according to Companies' records;
    c. Twists or attempts to twist any policyholder or Agent of Companies;
    d. Violates or breaches any term of this Agreement;
    e. Fails or refuses to surrender upon demand records or property of Companies which may have come into Agency's hands as custodian or otherwise;
    f. Agency's license to perform the functions required under this Agreement is suspended, cancelled or revoked for cause by the state of South Carolina or any regulatory body thereof;
    g. Fails to furnish proof of licensing satisfactory to the Companies within forty-eight (48) hours of a request by the Companies for such proof;
    h. Fails to maintain or provide proof of Errors and Omissions insurance coverage as required in this Agreement; or
    i. Unprofessional or inappropriate conduct of the Agency as determined by the Companies at its sole discretion.
4. The Companies reserve the right to cease paying commissions upon the effective date of cancellation under termination provisions or as directed by the South Carolina Department of Insurance.
5. The Companies reserve the right to terminate the appointment of any and all Producers or sub-agents, for any reason, or at the direction of the South Carolina Department of Insurance.
6. Upon termination of this Agreement, all books, supplies and documents containing the records of the business of the Companies shall be promptly delivered to the Companies. The Agency shall further allow the Companies full liberty to inspect and to take notes of all information as to the business of the Companies which belongs to the Agency.

XIII. ADVERTISING, POLICY FORMS AND SERVICE MARKS

1. Agency shall not re-market or package the Companies' products without the express written consent of the Companies. Agency has no authority, implied or otherwise to advertise or otherwise use Companies logos, policies or other references, printed and/or electronic in any newspaper, periodical, circular, or other marketing communication materials, printed or electronic, except upon prior written approval of an officer of the Companies.

2. Agency understands and agrees that the names "Blue Cross" and "Blue Shield" and the Blue Cross and Blue Shield symbols and marks and all rights, titles and interests therein (including without limitation any service marks, copyright, patent, trademark and other intellectual property rights therein) (collectively, the "Marks") are the property of or licensed to Companies, and Agency and employees receive no rights, title or interests in or to the Marks except as expressly set forth herein. Agency shall not: (i) use, modify or alter the Marks; or (ii) alter, destroy or otherwise remove any proprietary notices or labels containing the Marks, in any manner, without the prior written consent of Companies.

3. Companies shall supply promotional materials and applications for policies and shall prescribe all policy forms and rates to be used in connection with performance under this Agreement. Agency agrees to use only those materials, applications, forms and rates provided by Companies. Agency shall not, and shall not permit its agents, sub-agents or employees to alter, modify or amend any promotional materials, applications, policy forms or rates provided by Companies. In addition, no circular, advertisement, letterhead, telephone directory advertisement or other matter or materials that includes the name of or refers to the Companies or the Marks, as defined below, shall be printed, published or used to include, but not limited to printed or electronic media, in any way, by Agency unless Companies has given advance written approval thereof.

4. Other than sales literature, all material that the Companies furnish for Agency's use is confidential information and shall not be unnecessarily distributed or disclosed by Agency, without Companies' written permission or except as may be required by law.

5. The Agency expressly acknowledges that this Agreement constitutes a contract solely between Agency and Companies. Blue Cross and Blue Shield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. (and is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.) The "Association" permits Blue Cross and Blue Shield of South Carolina to use the Blue Cross and Blue Shield service marks in the state of South Carolina, and Blue Cross and Blue Shield of South Carolina is not contracting as an representative of the Association. Agency further acknowledges and agrees that it has not entered into this Agreement based upon representations by any entity other than Companies. No person, entity, or organization other than Companies shall be held liable or accountable to Agency for any of Companies' obligations created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of Companies or Blue Cross and Blue Shield of South Carolina other than those obligations created under other provisions of this Agreement. The Agreement is effective the day signed by a representative of Companies.

XIV. REPORTS AND AUDITS

1. Agency shall maintain at its principal office, files and records concerning this Agreement and books and records of all transactions between itself, it's Producers, sub-agents, employees, Companies and the Individual/Group. These books and records shall be maintained in accordance with prudent standards of insurance record keeping. Companies acknowledge that it accepts properly-forwarded automated or electronic copies of files in lieu of hard copy files.

2. Agency shall maintain and may not destroy any and all books, accounts and records of Agency related to Companies' Policies, and the same shall be subject to audit and inspection by Companies or its duly authorized representative at all times while this Agreement is in force and for seven (7) consecutive years after termination of this Agreement. Companies may, at any time, make copies of or take extracts from such books, accounts and records, as it may deem necessary.

3. Agency shall fully cooperate with any audit or examination by any government or authorized agencies and shall allow access to books and records maintained by Agency pursuant to this Agreement. Agency shall notify Companies within three (3) business day of any such audit or examination subject to this Agreement. Companies shall have the right to audit Agency during the term of this Agreement and for a seven (7) year period thereafter.

XV. LICENSES AND TAXES

1. Agency shall maintain all licenses required by the Companies, the state of South Carolina, and/or local laws and regulations to engage in business as an insurance agency, or Agency.

2. Agency agrees to notify the Companies within one business day of any termination, suspension, or expiration of Agency's license, or of any license held by its Producers, employees, or sub-agents, or of any regulatory sanctions imposed against Agency, its Producers, sub-agents or employees. Upon request, Agency will furnish to the Companies written proof of licensing.

XVI. AMENDMENT AND MODIFICATION

1. Companies reserve the right to amend and/or modify this Agreement unilaterally upon thirty (30) days prior notification, including the referenced commission schedule(s). Companies may provide notification by means of letter, newsletter, printed materials, electronic mail or other media.

2. Blue Cross and Blue Shield of South Carolina approved the above Agreement on behalf of itself and its family of companies, subject to all the provisions herein.

IN WITNESS WHEREOF, Company and Business Associate execute this Agreement in multiple originals to be effective on the last date written below.

☐ I Accept, Electronic Signature**.** By selecting "I Accept" you are signing this document electronically. You agree your electronic signature is the legal equivalent of your manual/handwritten signature on this document. By selecting "I Accept" using any device, means or action, you consent to the legally binding terms and conditions of this document. You further agree that your signature on this document (hereafter referred to as your "E-Signature") is as valid as if you signed the document in writing. You also agree that no certification authority or other third party verification is necessary to validate your E-Signature, and that the lack of such certification or third party verification will not in any way affect the enforceability of your E-Signature or any resulting document between you and BlueCross BlueShield of South Carolina.

Agent / Agency Representative	**Blue Cross and Blue Shield of South Carolina**
E-Signature:	By: Stephanie L. DeFreese
Title:	Name: Stephanie DeFreese
Agency SCDOI #:	Title: Vice President, Agency Sales
Date:	Date: 07/06/2017
BlueChoice HealthPlan of South Carolina, Inc.	**Companion Life Insurance Company**
By:	By:
Name: David Gwin	Name: Trescott N. Hinton Jr.
Title: Vice President, Sales	Title: President
Date: 07/06/2017	Date: 07/06/2017

Forms MUST be completed in their entirety, saved and emailed to Agent.Appointment@bcbssc.com.
For questions concerning Agent Appointments, please email Appointment.Inquiry@bcbssc.com.