

Important Notice Regarding Your Appointment for the Sale of Products Offered by Capital BlueCross, Capital Advantage Insurance Company, and Keystone Health Plan Central

Capital BlueCross, Capital Advantage Insurance Company, and Keystone Health Plan Central are sometimes referred to throughout this Appointment Disclosure Form as the “Appointing Entities.”

- Prior to appointing or reappointing a licensed insurance producer (“producer”), Pennsylvania law requires insurance companies that are authorized to transact business within Pennsylvania to make reasonable inquiry to: (i) determine whether the producer could be disqualified from obtaining a new or renewal producer’s license under applicable Insurance Department regulations; and (ii) verify other information relevant to the producer’s fitness to conduct the business of insurance.
- In addition, under federal law, any person who has been convicted of any criminal felony involving dishonesty or breach of trust is prohibited from engaging in the insurance business without the consent of the Pennsylvania Insurance Commissioner.
- Capital BlueCross, Capital Advantage Insurance Company, and Keystone Health Plan Central require that each producer read and understand the Capital BlueCross Code of Conduct. The Code of Conduct is available at the Capital BlueCross Web site (www.capbluecross.com/AboutCBC/CodeofConduct) or upon request from Capital BlueCross Broker Relations. By accepting your producer appointment from Capital BlueCross, Capital Advantage Insurance Company, and Keystone Health Plan Central, you agree to conduct business in accordance with the Code of Conduct and to report any actual or potential conflicts of interest to Capital BlueCross, Capital Advantage Insurance Company, and Keystone Health Plan Central.
- Capital BlueCross, Capital Advantage Insurance Company, and Keystone Health Plan Central may share your responses to the attached Appointment Disclosure Form with their vendors for certain ancillary products such as dental, vision, and stop-loss coverage. These vendors may, in turn, rely upon your responses in order to appoint you for the sale of their respective insurance products.

The Appointing Entities will rely upon your responses to the attached Appointment Disclosure Form when appointing you.

APPOINTMENT DISCLOSURE FORM CHECKLIST

- ✓ If you are applying as the “designated licensee” of an insurance agency, please complete Form C-8 and instruct all your licensed producers to complete Form C-7.
- ✓ If you are applying as an individual producer, please complete Form C-7.
- ✓ Have you read the Capital BlueCross Code of Conduct?
- ✓ Have you legibly printed or typed your responses to the Appointment Disclosure Form?
- ✓ Have you attached a copy of your current individual producer’s license?
- ✓ Have you attached a copy of your current business entity license?
- ✓ Have you signed and dated your Appointment Disclosure Form?

APPOINTMENT DISCLOSURE FORM C-8 (AGENCY)

PART A – PLEASE PROVIDE THE FOLLOWING INFORMATION ABOUT YOURSELF

NOTE: A designated licensee must complete this disclosure form.

Your Full Name: _____

If you have used any other name(s) over the past ten years, please identify your other name(s):

Your Social Security Number: _____ - _____ - _____

Prior Name: _____

Dates of Use: _____ to _____

Identify the date on which the Pennsylvania Insurance Department most recently issued/renewed your individual producer’s license: ____/____/____ **PLEASE ATTACH A COPY OF YOUR CURRENT INDIVIDUAL PRODUCER’S LICENSE.**

Your Business Address: _____ City _____ State _____ ZIP _____

Your Business Telephone Number: (____) _____ Your Primary Residence Telephone Number: (____) _____

Your Primary Residence Address: _____ City _____ State _____ ZIP _____

Your Primary Email Address: _____

Has your application for a producer’s license (“license”) been denied, or has an existing license been suspended, revoked, or not renewed by any insurance regulatory entity in any state, territory, or possession of the United States, the District of Columbia, or any Canadian province?

No Yes If yes, please disclose on a separate sheet the date, location, and reason for the denial, suspension, or revocation.

Have you engaged in any conduct which the insurance regulatory entity of any state, territory, or possession of the United States, the District of Columbia, or any Canadian province has determined to be in violation of the applicable insurance law of that jurisdiction, and as a result of that determination you paid a fine, signed a consent decree, or for which you received a warning or a letter of reprimand?

No Yes If yes, please disclose on a separate sheet the date and nature of the violation and sanction.

Have you ever pleaded guilty, entered a no contest plea, or been convicted of **any crime**, including, but not limited to, the following:

- Unlawful advertising of insurance business
- Unlawful coercion in contracting insurance
- Furnishing free insurance as an inducement for purchases
- Unlawful collection practices
- Embezzlement
- Obtaining money under false pretenses
- Conspiracy to defraud
- Bribery or corrupt influence
- Perjury or false swearing
- Unlicensed agent activity
- Criminal offense involving moral turpitude or harm to another

No Yes If yes, please disclose on a separate sheet the nature of the offense, name and address of the court, date of conviction, or entry of either a guilty plea or a no contest plea, and the sentence imposed. (Do not include traffic violations or citations in your response to this item.) Do not limit your disclosure to the crimes listed above.

Have you ever been short on an account with an employer or other party for whom you have held funds?

No Yes If Yes, please explain on a separate sheet.

Have you ever had an application for bond denied?

No Yes If yes, please disclose on a separate sheet the basis for and date of the denial.

Professional References: Please identify two individuals who are not related to you who can provide professional references on your behalf. We prefer licensed insurance producers as references, if possible.

Name: _____ Employer: _____ Telephone: (____) _____ Licensed insurance producer?
Yes No
Address: _____

Name: _____ Employer: _____ Telephone: (____) _____ Licensed insurance producer?
Yes No
Address: _____

15. Please disclose your employment history for the past **ten** years (Attach separate sheet(s) if necessary):

Current Employer

Name: _____
Address: _____

Contact Person: _____
Title: _____
Telephone: (____) _____
Employment Dates: From: _____ To: Present

May we contact to verify
your employment?
Yes No

Prior Employer

Name: _____
Address: _____

Contact Person: _____
Title: _____
Telephone: (____) _____
Employment Dates: From: _____ To: _____

May we contact to verify
your employment?
Yes No

Prior Employer

Name: _____
Address: _____

Contact Person: _____
Title: _____
Telephone: (____) _____
Employment Dates: From: _____ To: _____

May we contact to verify
your employment?
Yes No

Prior Employer

Name: _____
Address: _____

Contact Person: _____
Title: _____
Telephone: (____) _____
Employment Dates: From: _____ To: _____

May we contact to verify
your employment?
Yes No

PART B – PLEASE PROVIDE THE FOLLOWING INFORMATION ABOUT YOUR AGENCY

16. Your Agency is licensed as a: Corporation Partnership
17. Agency Name: _____
18. Agency Address: _____ City _____ State _____ ZIP _____
19. Agency Telephone Number: (____) _____
20. Federal Tax Identification Number: _____
21. Incorporation Date/Partnership Formation Date: ____/____/____
22. Identify the date on which the Pennsylvania Insurance Department most recently issued/renewed the agency's business entity license:
____/____/____ **PLEASE ATTACH A COPY OF YOUR AGENCY'S CURRENT BUSINESS ENTITY LICENSE.**
23. Identify all individual producers who will be producing on behalf of your agency and who will, therefore, require appointments:

Agent's Full Name:	Social Security Number:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ALL PRODUCERS MUST COMPLETE INDIVIDUAL APPOINTMENT DISCLOSURE FORM C-7.

REPRESENTATIONS, WARRANTIES, AND ACKNOWLEDGMENTS

- I hereby certify that the foregoing answers and statements are true to the best of my knowledge and belief and that I am a designated licensee (as defined by the Pennsylvania Insurance Department) for my agency.
- I acknowledge and affirm that I have a continuing obligation to inform Capital BlueCross, Capital Advantage Insurance Company, and Keystone Health Plan Central (the "Appointing Entities") if I plead guilty to, enter a no contest plea to, or am convicted of any crime.
- I acknowledge and affirm that I have a continuing obligation to report to the Appointing Entities any conduct, activity, or event that occurs subsequent to the date on which I have signed this disclosure form, that would have required disclosure in response to questions 9, 10, and 11.
- I acknowledge and understand that each of the Appointing Entities may conduct a criminal background check and that my appointment, and the appointment of my agency, may be affected by the information obtained in response to such inquiry, up to and including the termination of my appointment and my agency's appointment.
- I acknowledge and understand that my answers to the foregoing inquiries may prompt further inquiry by each of the Appointing Entities, to which I agree to provide truthful responses.
- I acknowledge and affirm that I have read the Capital BlueCross Code of Conduct, that I understand it, and that I agree to comply with it.
- I agree to comply with all the regulations of the Appointing Entities and the Pennsylvania Insurance Department. I certify that I am free to contract with the Appointing Entities. I authorize the individuals or companies identified as references or employers in this Appointment Disclosure Form to give to the Appointing Entities any business or personal information concerning me that they may have, and I release said individuals or companies from all liabilities for any damage whatsoever for issuing this information. I understand that my appointment must be processed with the Pennsylvania Insurance Department prior to receiving any commissions.
- I consent to Capital BlueCross, Capital Advantage Insurance Company, and Keystone Health Plan Central sharing copies of this disclosure form with certain vendors of ancillary insurance products to facilitate my appointment for such vendors.

Signature of Designated Licensee _____ Date: _____

Preferred Agent Approval: _____ <div style="display: flex; justify-content: space-around; width: 100%;">SignatureDate</div>
Capital BlueCross Approval: _____ <div style="display: flex; justify-content: space-around; width: 100%;">SignatureDate</div>