



Broker Contract

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This is step-by-step guide to becoming a member of our Team.

Important Notice: Globe Life Group Benefits does not contract any corporations in the state of Kansas or Massachusetts.

Required Documents

Complete, sign, date. *Return all pages.*

<input type="checkbox"/> Table of Contents and Acknowledgment	1
Guide to required forms and acknowledgment of review of supplemental forms.	
<input type="checkbox"/> Data Sheet (Independent Agent/Designated Agent Section)	2
Complete top for individual information only.	
<input type="checkbox"/> Data Sheet (Corporation/Agency Section)	3
Complete top for Principal Agent, bottom portion for Corporation.	
A unique business and personal email address is needed in order to access statements.	
The Company will correspond with the email listed on the business line.	
<input type="checkbox"/> Authorization to Obtain Information	4
<input type="checkbox"/> Broker Agent/Agency Agreement	5
If applying as an agency, "Broker" should be completed as follows: Broker Name/Business.	
<input type="checkbox"/> Business Associate Agreement "BAA"	9
Print effective date. If applying as an agency, "Business Associate" should be completed as follows: Broker Name/Business (Pg. 8), sign last page of agreement (Pg. 11).	
<input type="checkbox"/> Fair Credit Reporting Act Authorization and Acknowledgment	13
Complete form, sign, and date.	
<input type="checkbox"/> Debit-Check Agent/Agency Authorization Form	14
Complete form, sign, and date.	
<input type="checkbox"/> W-9 Tax Form (Full IRS Form: www.irs.gov/pub/irs-pdf/fw9.pdf)	15
If applying as an individual, complete with individual data	
If applying as an agency, complete with agency data	
<input type="checkbox"/> Direct Deposit EFT Form	16
Complete form, sign, and date.	

Return all contracting to your Globe Life Group Benefits point of contact. Please note: If any of the required forms listed below are not complete when returned with your paperwork, it will delay the time necessary to conclude the activation process.

Required Acknowledgment

I acknowledge receipt and review of these items:

- Fair Credit Reporting Act <https://home.globelifeinsurance.com/files/licensing/fair-credit-reporting-act.pdf>
 - Disclosure Statement
 - Summary of your Rights
 - Additional State Law Notices
- Broker Proposed Commission Schedule and Calendar (Attached separately)

Applicant Signature _____ Date Signed _____

Individual Appointment **Agency Appointment**

NPN: _____

Note: Agency appointment must include a designated agent appointment.

Applicant Information (Please Print)			
Full Name		Social Security Number	
Residential Address			
Address			Suite #
City		State	ZIP Code
Phone	Fax	Mobile	
Email Address <i>(By providing an email address, I authorize the Company to communicate with me via email for all Company correspondence.)</i>			
Business Address			
Address			Suite #
City		State	ZIP Code
Phone	Fax	Mobile	
Email Address <i>(By providing an email address, I authorize the Company to communicate with me via email for all Company correspondence.)</i>			
Additional Information			
Have you ever gone by another name? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If Yes, please list)</i>			
Are you a citizen of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Information required by State Insurance Departments			
Have you ever been convicted of a felony? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If Yes, enclose court documents and an explanation)</i>			
Have you ever been refused, had suspended, or revoked an insurance license in any state? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you owe an unpaid balance to any insurance company? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If Yes, enclose particulars)</i>			
List any nonresident states you wish to be appointed in <i>(must be licensed)</i> :			

Corporation/Agency–Information (C-Corp, S-Corp, LLC)

Agency NPN: _____

Important Notice: We do not contract with any corporations in the state of Kansas or Massachusetts.

Corporation/Agency Information			
Full Name		Tax ID Number	
Corporation/Agency Address			
Address			Suite #
City		State	ZIP Code
Phone	Fax		Mobile
Email Address <i>Note: This email must differ from the one above. (By providing an email address, I authorize the Company to communicate with me via email for all Company correspondence.)</i>			

I certify that my answers are true and complete to the best of my knowledge.

I AUTHORIZE ANY CONSUMER REPORTING AGENCY, or any other organization, or person having knowledge of my character, reputation and financial position to give one or more of the subsidiaries of Globe Life Inc. (i.e., American Income Life Insurance Company, National Income Life Insurance Company, Liberty National Life Insurance Company, United American Insurance Company, Globe Life And Accident Insurance Company, Globe Life Insurance Company of New York, and/or Family Heritage Life Insurance Company of America) (individually and collectively, the "Company") any and all such information. I understand that the information obtained by use of this authorization will be used by the Company to determine eligibility for agent appointments, and for other business purposes in connection with our relationship. I hereby release the above parties from all liability for any damage that may ensue from furnishing any information in response to this authorization.

I give my consent to the Company to perform periodic criminal and credit history background checks in any state, including Georgia, prior to, and up to, termination of my appointment with the Company.

I understand that any information obtained will not be released by the Company to any person or organization except to persons or organizations performing business or legal services in connection herewith.

However, the Company may release such information to any of its affiliates in connection with my request for an appointment with such affiliates.

I know that I may request to receive a copy of this authorization and the report. I understand and agree that a photographic copy of this Authorization shall be valid as the original.

Signature of Applicant

Date

Privacy Notice

The Company, in connection with your application to be an independent contractor for the Company, or in connection with your relationship with Company as an independent contractor, may collect and maintain information about you for the purpose of evaluating your application, maintaining your relationship with Company, offering or servicing benefits you may obtain through Company, or any other business-related purpose ("Independent Contractor Information"). Independent Contractor Information may include (1) unique identifiers, such as your real name, alias, postal address, unique personal identifier, online identifier, Internet Protocol address, email address, account name, Social Security number, driver's license number, passport number, or other similar identifiers; or (2) personal information categories listed in the California Customer Records statute, such as your signature, physical characteristics or description, address, telephone number, state identification card number, insurance policy number, education, employment, employment history, bank account number, credit card number, debit card number, or any other financial information, medical information, or health insurance information.

This Producer Agreement ("Agreement") is entered into effective as of and is by and between Globe Life And Accident Insurance Company, a Nebraska corporation, (hereinafter referred to as "Company") and the undersigned broker (hereinafter referred to as "Broker"). Broker and Company, jointly, shall hereinafter be referred to as "the Parties" and each individually as a "Party."

WHEREAS, Broker is an agency or individual that has established relationships with certain prospective clients and/or tools and resources to establish relationships with prospective worksite accounts; and

WHEREAS, Broker will provide services to the Company's Broker sales division in efforts to make connections between Company and prospective clients for the introduction of Company's suite of supplemental employee benefit products.

WHEREAS, Company will benefit from Broker's provision of Services; and

WHEREAS, Company wishes to engage Broker for the purpose of providing Services.

NOW THEREFORE, in consideration of the mutual covenants contained herein and other good and valuable consideration, the parties hereby agree as follows:

1. **APPOINTMENT AND LICENSING.** Unless otherwise required by law or Company policy, Broker shall be responsible for obtaining, at his expense, all licenses required by any governmental entity for transacting business under this Agreement. Broker understands and acknowledges that Company shall pay no compensation to Broker unless and/or until such time as Broker is appropriately licensed and appointed by Company, where applicable.
2. **RELATIONSHIP OF PARTIES.** The Parties acknowledge and agree that Broker shall be considered an independent contractor. No agency, partnership, joint venture or employer-employee relationship is intended or created by this Agreement and neither of the Parties can create any such obligation for the other Party. Neither of the Parties is granted any right or authority to assume or create any obligation or responsibility, express or implied, on behalf of or in the name of the other Party. The Parties may not bind one another in any manner.
3. **LIMITED AUTHORITY.** Broker is not authorized to make or amend any contract, incur any debt, or extend any credit on behalf of Company; or alter, waive or modify any of the terms, conditions or limitations of any application for insurance or policy issued by Company; or waive any of Company's rights or privileges under any agreement made by Company or under Company policies and procedures. Broker agrees that if he obligates Company in any manner prohibited by this section, Broker shall be liable to Company for any loss resulting therefrom, including but not limited to costs and attorney fees incurred by Company in defending claims asserted by third parties.
4. **COMPENSATION OF BROKER.**
 - (A) **Commissions.** Company agrees to pay Broker commissions on policies issued during the term of this Agreement in accordance with the Commission Rate Schedule attached hereto. Commissions will be paid only on premiums actually received by Company on business produced as a direct result of Broker's Services less any premiums returned to the insured for any reason. In the event Company shall, either during the continuance of this Agreement or after its termination, refund premiums under any policy to an Insured for any reason, Broker shall immediately repay to Company the amount of any commission paid him on the premium so refunded. Company has the right, by offset or otherwise, to recover commissions made in error.
 - (i) All commissions shall be based only on premium actually received by Company. Commissions will be calculated only on those premiums paid by or on behalf of the insured. No commissions shall be paid on interest, or on premium waived or commuted by reason of death, disability or exercise of policy options. First-year commissions shall be based upon annual premium for the first insurance policy year. Renewal commissions shall be based upon the premiums received by Company for the policy year for which such Renewal commission is payable, as set out in the attached Commission Rate Schedule.
 - (ii) Company may, at any time while this Agreement is in force or after its termination, set off against any claims by Broker for commission or other monies accruing to the account of Broker under the terms of

this Agreement any debts, liabilities or obligations of Broker to Company or its affiliates, from any source. Company may offset commissions otherwise due Broker against any indebtedness owed by Broker to Company or its affiliates, irrespective of whether demand for payment has been made. All amounts owed to Company or its affiliates by Broker shall become due and payable immediately. If any such indebtedness shall remain unpaid, Broker will remain indebted to Company until it is paid in full and Broker shall be responsible for reasonable attorney's fees and costs incurred by Company to collect the indebtedness

- (iii) Company reserves the right to alter, increase, decrease, modify or withdraw the Commission Rate Schedule upon ninety (90) days' written notice; in such event, Company will provide Broker an updated Commission Rate Schedule. However, any changes shall apply from and after the effective date of such change on business produced after that date. Company shall determine the commission on any policy which is determined to be a replacement or conversion of an existing policy.
- (iv) This Agreement does not give Broker any exclusive rights in the territory in which he may work, nor establish any claim on his part to commissions on business secured by or through other Brokers.

5. **TERM AND TERMINATION.**

(A) Term. This Agreement shall commence on the effective date and the initial term shall continue thereafter for a period of one (1) year, unless it is terminated earlier pursuant to Section 6 (B) of this Agreement. At the end of the initial term, unless terminated earlier, this Agreement will remain in full force and effect and will renew automatically for additional one (1) year renewal terms unless and until this Agreement is terminated in accordance with this Section 6 (B).

(B) Termination. This Agreement may be terminated by either Party upon thirty (30) days written notice to the other Party. If Broker engages in any act of dishonesty or malfeasance in the performance of the Services, or if Broker breaches this Agreement, then this Agreement and Broker's right to receive further commissions hereunder shall immediately terminate upon written notice.

- 6. **PERIODIC STATEMENTS.** Company will provide Broker a periodic statement of compensation. Broker agrees to examine each periodic statement and to notify Company, in writing, of specific mistakes or discrepancies in the statement. Failure of Broker to so notify Company of any mistakes or discrepancies in writing within ninety (90) days of receipt of the statement shall be an admission of the correctness of such statement and shall bar any claims to the contrary against Company.
- 7. **EXPENSES.** Broker shall be responsible for all expenses it incurs in the performance of his obligations under this Agreement, including but not limited to expenses for transportation, office space, supplies, appointment fees, advertising, training, and licensing, if applicable.
- 8. **ADVERTISING.** Broker shall not, without the prior written approval of Company, publish or distribute any advertising material, supplies or other printed or written material concerning Company or its products.
- 9. **COMPANY'S RIGHT TO CANCEL POLICIES.** Company reserves the right to reject any application for insurance and to cancel, refuse to renew or modify, in accordance with policy provisions, any policy issued by Company.
- 10. **MODIFICATION.** This Agreement may be altered or amended only by a written amendment to this Agreement signed by each of the Parties hereto.
- 11. **ASSIGNMENT.** No assignment of this Agreement or of any commissions accrued or to accrue under this Agreement shall be valid as against Company unless authorized in writing by Company.
- 12. **WAIVER.** Failure of either party to insist upon strict compliance with any provision of this Agreement shall not constitute a waiver of such provision or any other provision.
- 13. **NOTICE.** Any written notice, request, instruction or document to be given under this Agreement by any Party to the other Party may be delivered personally or sent electronically or by first class mail, with postage duly affixed, to the other Party at their last known address. Electronic notice to Broker from Company shall be delivered by transmission of an e-mail to Broker at the email address kept in Company's files.

- 14. SEVERABILITY.** If any one or more of the provisions contained in the sections and subsections of this Agreement shall, for any reason, be held to be invalid, illegal or unenforceable, such invalidity, illegality, or unenforceability shall not affect any other provisions of this Agreement and this Agreement shall be construed as if such invalid, illegal or unenforceable provisions had never been contained within.
- 15. ENTIRE AGREEMENT.** This Agreement contains the complete Agreement between the Parties and each Party hereby warrants that there are no prior agreements or representations that are not set forth herein.
- 16. PRIVACY.** Each party shall comply with all applicable federal and state laws protecting the privacy of nonpublic personal information of individuals. To the extent that either party discloses nonpublic personal information of any individual to the other party, the other party agrees not to use or disclose the information other than to carry out the purposes for which the disclosing party disclosed the information to the other party.
- 17. GENDER.** The use of the masculine gender shall include the feminine gender and the use of the singular shall include the plural where appropriate.
- 18. CHOICE OF LAW.** This Agreement shall be construed in accordance with the laws of the State of Texas. Any action or proceeding arising out of or related to this Agreement shall be brought on in the District Court of Collin County, State of Texas. The parties hereby consent to such venue and to the jurisdiction of such courts over such proceeding and themselves.
- 19. D TSA.** Notwithstanding any other provision of this Contract, nothing herein shall prohibit Independent Contractor from reporting possible violations of federal law or regulation to any governmental agency or entity or making other disclosures that are protected pursuant to federal law or regulation. Prior authorization from the Company is not required in order to make any such reports or disclosures and the reporting individual is not required to notify the Company that such reports or disclosures have been made. **IMMUNITY NOTICE.** Pursuant to the Defend Trade Secrets Act of 2016, an individual may not be held criminally or civilly liable under any federal or state trade secret law for the disclosure of a trade secret that is made in confidence to a federal, state, or local government official, either directly or indirectly, or to an attorney; and solely for the purpose of reporting or investigating a suspected violation of the law; or is made in a complaint or other document filed in a lawsuit or other proceeding, if such filing is made under seal. Should any provision in this Contract conflict with this provision, this provision shall control.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the day and year first above written.

GLOBE LIFE AND ACCIDENT INSURANCE COMPANY

By Chief Distribution Officer, DVP

Date

AND

Printed Name of Broker and Corporation/Business name
(when applicable)

Signature of Broker

This Business Associate Agreement is made effective on the ____ day of _____, 20____ by and between Globe Life Inc. and its subsidiaries (American Income Life Insurance Company, National Income Life Insurance Company, Liberty National Life Insurance Company, United American Insurance Company, Globe Life And Accident Insurance Company, Globe Life Insurance Company of New York, and Family Heritage Life Insurance Company of America) (individually and collectively, the "Company") and _____, hereinafter referred to as "Business Associate", (individually, a "Party" and collectively, the "Parties"). (Hereinafter referred to as the "Agreement")

WITNESSETH:

WHEREAS, Sections 261 through 264 of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, known as "the Administrative Simplification provisions," direct the Department of Health and Human Services to develop standards to protect the security, confidentiality and integrity of health information, and the "Health Information Technology for Economic and Clinical Health" ("HITECH") Act (Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5)) modified and amended the Administrative Simplification provisions; and

WHEREAS, pursuant to the Administrative Simplification provisions, the Secretary of Health and Human Services issued regulations modifying 45 CFR Parts 160 and 164 (the "HIPAA Rules"), as further amended by the Omnibus Final Rule (78 Fed. Reg. 5566), (hereinafter, the Administrative Simplification provisions, HITECH, such rules, amendments, and modifications, including any that are subsequently adopted, will be collectively referred to as "HIPAA"); and

WHEREAS, the Parties wish to enter into or have entered into an arrangement whereby Business Associate will provide certain services and/or products to Covered Entity, and, pursuant to such arrangement, Business Associate may be considered a "business associate" of Covered Entity as defined by HIPAA; and WHEREAS, Business Associate may have access to Protected Health Information in fulfilling its responsibilities under such arrangement; and

WHEREAS, Covered Entity and Business Associate may have previously entered into a Business Associate Agreement, the Parties now wish to supersede such prior agreement with this Agreement; THEREFORE, in consideration of the Parties' continuing obligations under the Arrangement Agreement, compliance with HIPAA, and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, and intending to be legally bound, the Parties agree to the provisions of this Agreement in order to address the requirements of HIPAA and to protect the interests of both Parties.

1. DEFINITIONS

Except as otherwise defined herein, any and all capitalized terms in this Section shall have the definitions set forth by HIPAA. In the event of an inconsistency between the provisions of this Agreement and mandatory provisions of HIPAA, HIPAA shall control. Where provisions of this Agreement are different from those mandated by HIPAA, but are nonetheless permitted by HIPAA, the provisions of this Agreement shall control.

2. BUSINESS ASSOCIATE OBLIGATIONS

Business Associate acknowledges and agrees that all Protected Health Information that is created, maintained, transmitted or received by Covered Entity and disclosed or made available in any form, including paper record, oral communication, audio recording, and electronic display by Covered Entity or its operating units to Business Associate, or Protected Health Information which, on behalf of Covered Entity, is created, maintained, transmitted or received by Business Associate or a Subcontractor, shall be subject to this Agreement.

(A) Business Associate agrees:

- (i) it is aware of and will comply with all provisions of HIPAA that are directly applicable to business associates;
- (ii) in the event it enters into an agreement with a Subcontractor under which Protected Health Information could or would be disclosed or made available to the Subcontractor, the Business Associate will have in place an appropriate Business Associate Agreement with the Subcontractor before any Protected Health Information is disclosed or made available to the Subcontractor;
- (iii) to use or disclose any Protected Health Information solely as would be permitted by HIPAA if such use or disclosure were made by Covered Entity: (1) for meeting its obligations as set forth in the Arrangement Agreement, or any other agreements between the Parties evidencing their business relationship, or (2) as required by applicable law, rule or regulation, or by accrediting or credentialing organization to whom Covered Entity is required to disclose such information or as otherwise permitted under this Agreement, the Arrangement Agreement (if consistent with this Agreement and HIPAA), or HIPAA. All such uses and disclosures shall be subject to the limits set forth in 45 CFR § 164.514 regarding limited data sets and 45 CFR § 164.502(b) regarding the minimum necessary requirements;
- (iv) at the request of the Secretary, to comply with any investigations and compliance reviews, permit access to information, provide records and compliance reports, and cooperate with any complaints, pursuant to 45 CFR § 160.310;
- (v) at termination of this Agreement, the Arrangement Agreement (or any similar documentation of the business relationship of the Parties), or upon request of Covered Entity, whichever occurs first, if feasible, Business Associate will return or destroy (and attest to the destruction of) all Protected Health Information received from Covered Entity or created or received by Business Associate on behalf of Covered Entity that Business Associate still maintains in any form and retain no copies of such information, or if such return or destruction is not feasible, Business Associate will extend the protections of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information not feasible;
- (vi) to ensure that its Subcontractors to whom it provides Protected Health Information received from Covered Entity or created or received by Business Associate on behalf of Covered Entity, agree to the same (or greater) restrictions and conditions that apply to Business Associate with respect to such information, and agrees to, pursuant to 45 CFR § 164.314, implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Covered Entity and ensure that any Subcontractors to whom it provides such information agrees to implement reasonable and appropriate safeguards to protect it. In addition, Business Associate agrees to take reasonable steps to ensure that its employees' actions or omissions do not cause Business Associate to breach the terms of this Agreement;
- (vii) Business Associate shall, following the discovery of a breach of unsecured Protected Health Information, as defined in HIPAA, notify Covered Entity of such breach pursuant to the terms of 45 CFR § 164.410 and cooperate in Covered Entity's breach analysis procedures, including risk assessment, if requested. A breach shall be treated as discovered by Business Associate as of the first day on which such breach is known to Business Associate or, by exercising reasonable diligence, would have been known to Business Associate. Business Associate will provide such notification to Covered Entity without unreasonable delay and in no event later than ten (10) calendar days after discovery of the breach. Such notification will contain the elements required in 45 CFR § 164.410. Covered Entity shall determine any required actions with respect to any such breach, and Business Associate shall cooperate with Covered Entity and comply with such actions; and
- (viii) Business Associate will not directly or indirectly receive remuneration in exchange for any Protected Health Information without a valid authorization from the applicable individual except in compliance with

45 CFR § 164.502(a)(5)(ii). Without written approval of Covered Entity, Business Associate will not engage in any communication which might be deemed to be "marketing" under HIPAA. In addition, Business Associate will, pursuant to HIPAA, comply with all applicable requirements of 45 CFR §§ 164.308, 164.310, 164.312 and 164.316.

- (B) Notwithstanding the prohibitions set forth in this Agreement, Business Associate may use and disclose Protected Health Information as follows::
- (i) if necessary, for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate, provided that as to any such disclosure, the following requirements are met:
 - (a) the disclosure is required by law; or
 - (b) Business Associate obtains satisfactory assurances through a written Business Associate Agreement from the Subcontractor to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the Subcontractor, and the Subcontractor notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached;
 - (ii) for data aggregation services, if to be provided by Business Associate for the health care operations of Covered Entity pursuant to any agreements between the Parties evidencing their business relationship. For purposes of this Agreement, data aggregation services means the combining of Protected Health Information by Business Associate with the Protected Health Information received by Business Associate in its capacity as a business associate of another covered entity, to permit data analyses that relate to the health care operations of the respective covered entities.
- (C) Business Associate will implement appropriate safeguards to prevent use or disclosure of Protected Health Information other than as permitted in this Agreement. Business Associate will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of any Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of Covered Entity as required by HIPAA.
- (D) The Secretary of Health and Human Services shall have the right to audit Business Associate's records and practices related to the use and disclosure of Protected Health Information to ensure Covered Entity's and Business Associate's compliance with the terms of HIPAA.
- (E) Business Associate shall report to Covered Entity any use or disclosure of Protected Health Information which is not in compliance with the terms of this Agreement of which it becomes aware. Business Associate shall report to Covered Entity any Security Incident of which it becomes aware promptly and in the manner required by Covered Entity to permit compliance with the requirements of HIPAA. In addition, Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.

3. AVAILABILITY OF PHI

Business Associate agrees to comply with any requests for restrictions on certain disclosures of Protected Health Information pursuant to 45 CFR § 164.522 to which Covered Entity has agreed and of which Business Associate is notified by Covered Entity. Business Associate agrees to make available Protected Health Information to the extent and in the manner required by 45 CFR § 164.524. If Business Associate maintains Protected Health Information electronically, it agrees to make such Protected Health Information electronically available to the applicable individual. Business Associate agrees to make Protected Health Information available for amendment and incorporate any amendments to Protected Health Information in accordance with the requirements of 45 CFR § 164.526. In addition, Business Associate agrees to make Protected Health Information available for purposes of accounting of disclosures, as required by 45 CFR § 164.528. Business Associate and Covered Entity shall cooperate in providing any accounting required on a timely basis.

4. TERMINATION

Notwithstanding anything in this Agreement to the contrary, Covered Entity shall have the right to terminate this Agreement and the Arrangement Agreement immediately if Covered Entity determines that Business Associate has violated any material term of this Agreement. If Covered Entity reasonably believes that Business Associate will violate a material term of this Agreement, where practicable, Covered Entity shall give written notice to Business Associate of such belief within a reasonable time after forming such belief. If Business Associate fails to provide adequate written assurances to Covered Entity that it will not breach the cited term of this Agreement within a reasonable period of time given the specific circumstances, but in any event, before the threatened breach is to occur, then Covered Entity shall have the right to terminate this Agreement and the Arrangement Agreement immediately.

5. MISCELLANEOUS

Except as expressly stated herein or in HIPAA, the Parties to this Agreement do not intend to create any rights in any third parties. The obligations of Business Associate under this Section shall survive the expiration, termination, or cancellation of this Agreement, the Arrangement Agreement and/or the business relationship of the Parties, and shall continue to bind Business Associate, its agents, employees, contractors, successors, and assigns as set forth herein.

AGREEMENT:

This Agreement may be amended or modified only in a writing signed by the Parties. No Party may assign its respective rights and obligations under this Agreement without the prior written consent of the other Party. None of the provisions of this Agreement are intended to create, nor will they be deemed to create any relationship between the Parties other than that of independent parties contracting with each other solely for the purposes of effecting the provisions of this Agreement and any other agreements between the Parties evidencing their business relationship. This Agreement will be governed by the laws of the State of Texas. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

The Parties agree that, in the event that any documentation of the arrangement pursuant to which Business Associate provides services to Covered Entity contains provisions relating to the use or disclosure of Protected Health Information which are more restrictive than the provisions of this Agreement, the provisions of the more restrictive documentation will control. The provisions of this Agreement are intended to establish the minimum requirements regarding Business Associate's use and disclosure of Protected Health Information.

In the event that any provision of this Agreement is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions of this Agreement will remain in full force and effect. In addition, in the event a Party believes in good faith that any provision of this Agreement fails to comply with the then-current requirements of HIPAA, such Party shall notify the other Party in writing. For a period of up to thirty days, the Parties shall address in good faith such concern and amend the terms of this Agreement, if necessary to bring it into compliance. If, after such thirty-day period, the Agreement fails to comply with HIPAA, then either Party has the right to terminate upon written notice to the other Party.

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the day and year written above.

COVERED ENTITY:

BUSINESS ASSOCIATE:



By Signed

By Signed

Divisional Senior Vice President and General Counsel

Title

Title

I acknowledge receipt of the Disclosure Statement regarding consumer and/or investigative reports and the Summary of Your Rights Under the Fair Credit Reporting Act and certify that I have read and understand both of the documents.

For California Residents, I acknowledge receipt of the Disclosure Statement regarding consumer and/or investigative reports pursuant to the California Investigative Consumer Reporting Agencies Act and the A Summary of Your Rights Under the Provisions of California Civil Code Section 1786.22, and I certify that I have read and understand both of the documents.

For Georgia Residents, I hereby authorize the Company to perform criminal and credit history background checks in Georgia, prior to and up to, termination of my appointment with the Company and/or it's affiliates.

For New Jersey Residents under the New Jersey Fair Credit Reporting Act, the Company is required to inform you if an offer of appointment is withheld due in whole or in part, to information contained in the Reports, and is required to provide you a copy of the Reports, upon request in writing within a reasonable period of time, and is required to provide you a description in writing of the rights you have under the New Jersey Fair Credit Reporting Act. If an adverse action is taken during your appointment, up to and including termination from appointment, due in whole or in part, to information contained in the Reports, the Company will provide you a copy of the Reports and a description in writing of the rights you have under the New Jersey Fair Credit Reporting Act. The Company is located and can be contacted by mail at 3700 S. Stonebridge Drive, McKinney, TX 75070 and the Company can be contacted by phone at 972-569-3785. You may request more information about the nature and scope of any investigative consumer reports, and the contact information of any consumer reporting agencies from whom the Company obtains your background reports, by contacting the Company.

I voluntarily and knowingly authorize the Company or its authorized agents, for appointment purposes only, and throughout my appointment as needed, to obtain consumer reports or investigative consumer reports as part of the process of my applying for appointment. I understand that if the Company appoints me or contracts for my services, my consent will apply, and the Company may obtain Reports, throughout my appointment. I understand that Reports may include information about my prior employment or military record, education, credit worthiness and history, character, general reputation, personal characteristics, criminal record, and mode of living. I understand that this information may be obtained through a variety of sources, including, but not limited to, public records, educational institutions, financial institutions, credit bureaus, and personal interviews with my current and former employers, friends, neighbors and associates. I understand that upon written request to the Company, I will be informed whether a Report was requested and given information as to the nature and scope of the Report.

I hereby authorize the Company to perform criminal and credit history background checks in any state, prior to and up to, termination of my appointment with the Company and its affiliates.

I request any current or former employer, educational institution, law enforcement department or agency, court, credit bureau, financial institution, licensing agency, governmental agency including the U.S. Armed Forces, or other individuals, organizations and sources to release and furnish any and all information on me that is requested by the Company and/or other consumer reporting agencies hired by the Company.

A photocopy of this authorization shall have the same force and effect as the original and shall be valid for this and any future reports or updates that may be requested. I agree to assist and cooperate with the Company's investigation of my background, including providing all the necessary documents requested by the Company.

California applicants only: By signing below, you also acknowledge receipt of A Summary of Your Rights Under the Provisions of California Civil Code Section 1786.22.

New York applicants only: By signing below, you also acknowledge receipt of Article 23-A of the New York Correction Law.

Washington State applicants only: By signing below, you also acknowledge receipt of A Summary of Your Rights Under the Washington Fair Credit Reporting Act.

For California, Minnesota, New Jersey and Oklahoma applicants only: Please check the appropriate box to indicate if you would like to receive a copy of your consumer report and/or investigative consumer report free of charge if one is obtained by the Company.

Yes No

Signature of Applicant

Date



Debit-Check Agent/Agency Authorization Form

Vector One Operations, LLC dba Vector One (collectively with its affiliates, "Vector One") manages the secured web portal interactive computer service provided by Debit-Check.com, LLC ("Debit-Check"). This Debit-Check Agent/Agency Authorization Form is by and among the undersigned ("you", "me", "I" or "my"), Vector One, and Globe Life and its subsidiaries (American Income Life Insurance Company, National Income Life Insurance Company, Liberty National Life Insurance Company, United American Insurance Company, Globe Life And Accident Insurance Company, Globe Life Insurance Company of New York, and Family Heritage Life Insurance Company of America) (individually and collectively, the "Company") and is used by Debit-Check subscribers who desire to be granted authorization from you for the submission and/or receipt of your personal information to the Debit-Check service as necessary to conduct a commission related debit balance screening. The Company and its affiliates and authorized third parties (collectively, the "Company") is a Debit-Check subscriber. Accordingly, as part of the contracting and appointment process or determination of eligibility for advancement of commissions, the Company may conduct a commission related debit balance screening via Debit-Check in order to determine your eligibility and may continue to conduct periodic commission related debit balance screenings as determined in the Company's sole discretion following the engagement of any employment, appointment, contract, tenure, or other relationship with the Company.

Access to Debit-Check Information: You can obtain your commission related debit balance information by contacting the Vector One Agent Hotline at (800) 860-6546.

AGENT/AGENCY'S STATEMENT – READ CAREFULLY

The Company is hereby authorized to obtain and conduct a commission related debit balance screening through Vector One's Debit-Check secured web portal to determine if another Debit-Check subscriber has posted that I have an outstanding commission related debit balance. I understand that the Company may consider the results of the commission related debit balance screening in order to determine my eligibility to be contracted and appointed or determine my eligibility for advancement of commissions as an insurance producer and may continue to conduct periodic commission related debit balance screenings as determined in the Company's sole discretion following the engagement of any employment, appointment, contract, tenure, or other relationship with the Company. I understand and acknowledge that the Company may obtain commission related debit balance information through Debit-Check as state law allows. I understand that my information, including my name and social security number ("My Information") may be used for the purpose of obtaining and conducting a commission related debit balance screening. I further understand that in the event of termination or expiration of my employment, appointment, contract, tenure, or other relationship with the Company, whether voluntary or involuntary, if a commission related debit balance is owed to the Company, the Company may post My Information to the Debit-Check service which may be accessed by Debit-Check subscribers until such time the debit balance is satisfied or otherwise removed.

BY SIGNING BELOW, I HEREBY:

Authorize the Company to use My Information for purposes of conducting a commission related debit balance screening, and periodic commission related debit balance screenings as determined in the Company's sole discretion following the engagement of any employment, appointment, contract, tenure, or other relationship with the Company, utilizing Debit-Check.

Authorize the Company to consider the results of the commission related debit balance screening in order to determine my eligibility to be contracted and appointed or determine my eligibility for advancement of commissions as an insurance producer.

Authorize and direct Vector One to receive and process My Information as necessary to intentionally disclose and furnish the results of my commission related debt verification screening, whether directly or indirectly, to the Company.

Authorize the Company to submit My Information to the Debit-Check service in the event of termination or expiration of my engagement with the Company, whether voluntary or involuntary, to the extent a commission related debit balance is owed to the Company.

Authorize and direct Vector One to receive and process My Information and intentionally disclose to any Debit-Check subscriber who submits an inquiry utilizing My Information the results of my commission related debit balance screening, which will contain My Information, to the extent a debit balance is owed.

Acknowledge that this authorization may be signed, electronically or manually, in counter parts, each of which shall be deemed an original, but both of which together shall constitute one and the same instrument.

Agent/Agency Printed Name: _____

Signature: _____

Date: _____

Request for Taxpayer Identification Number and Certification

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

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

Print or type.	See Specific Instructions on page 3.	<p>1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.</p>	
		<p>2 Business name/disregarded entity name, if different from above</p>	
		<p>3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only one of the following seven boxes.</p> <p> <input type="checkbox"/> Individual/sole proprietor or single-member LLC <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____ Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner. <input type="checkbox"/> Other (see instructions) ▶ _____ </p>	<p>4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):</p> <p>Exempt payee code (if any) _____</p> <p>Exemption from FATCA reporting code (if any) _____</p> <p><small>(Applies to accounts maintained outside the U.S.)</small></p>
		<p>5 Address (number, street, and apt. or suite no.) See instructions.</p>	<p>Requester's name and address (optional)</p>
		<p>6 City, state, and ZIP code</p>	
		<p>7 List account number(s) here (optional)</p>	

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number								
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Part II Certification

Under penalties of perjury, I certify that:

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

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	<p>Signature of U.S. person ▶ _____</p>	<p>Date ▶ _____</p>
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General Instructions

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

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

Purpose of Form

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

- Form 1099-INT (interest earned or paid)

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

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

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

Authorization for Direct Deposits

Business Name _____ Producer Number _____

Business Address _____

Primary Contact _____ Phone _____ Email _____

Secondary Contact _____ Phone _____ Email _____

I hereby authorize and instruct **Globe Life Group Benefits** (the "Company"), to deposit the amount of each of my commission payments directly into my checking and / or savings account as indicated below in the Deposit Instructions and to make any such withdrawals directly from my account or accounts as are necessary to correct any incorrect deposit by the Company under this Authorization.

I further hereby authorize and instruct the financial institution named below (the "Institution") to accept such automatic deposits to or withdrawals from my account or accounts by the Company and to cause my account or accounts to be automatically credited or debited (as the case may be) in the amount of such deposits or withdrawals by the Company without any responsibility for the correctness of any such deposit or withdrawal. I hereby Authorize Third Party Administrators of Globe Life Group Benefits to make such transactions on their behalf (Gilsbar HealthComp, Administrative Concepts, Inc., and The Loomis Company).

Primary account institution:

Institution _____

Institution Address _____

(City)

(State)

(ZIP)

Deposit Instructions *(Please check appropriate boxes)*

Deposit the full amount of my net pay to my account number _____ Checking
Routing _____ Savings

Please cancel my automatic payroll deposit(s).

Forward this completed form to GLBAppointments@Globe.Life.

I understand that I can cancel this authorization at any time. To cancel, I must give written notice to both the Company and the Institution. My cancellation will become effective as to the company when the Company receives my notice of cancellation and has had a reasonable period of time upon which to act on it. Any automatic deposits to or withdrawals from my account or accounts by the Company up until that time will be authorized by this authorization. My cancellation of this authorization will become effective as to the Institution when the Institution receives my notice of cancellation and has had a reasonable period of time upon which to act on it. Any automatic credits or debits made to my account or accounts by the Institution up until that time will be authorized by this authorization.

I further understand that all automatic deposits and credits to or withdrawals and debits from my account or accounts under this authorization will be subject to all rules, regulations, agreements and disclosure statements of the Company and the Institution governing accounts and preauthorized transfers to and from accounts.

I hereby state that I received a completed copy of this authorization on the date I signed the authorization.

Print Name: _____ Signature: _____

Date: _____

PLEASE RETAIN COPY FOR YOUR RECORDS

NACHA Terms and Conditions

ACH transactions are regulated. The following terms and conditions are a required component of any ACH agreement.

Authorization to Originate Entry: With respect to each and every Entry transmitted by Company, Company represents and warrants to Administrator and agrees that (a) each person or entity shown as the Receiver on an Entry received by Administrator from Company has authorized the initiation of such Entry and the crediting or debiting of its account in the 'amount and on the Effective Entry Date shown on such Entry, (b) such authorization is operative at the time of transmittal or crediting or debiting by Administrator as provided herein, (c) Entries transmitted to Administrator by Company are limited to those types of credit and debit Entries set forth in the Agreement, (d) Company shall perform its obligations under this Agreement in accordance with all applicable laws, regulations, and orders, including, but not limited to, the sanctions laws, regulations, 'and orders administered by OFAC; laws, regulations, and orders administered FinCEN; and any state laws, regulations, or orders applicable to the providers of ACH payment services, and (e) Company shall be bound by and comply with the provision of the Rules (among other provisions of the Rules).

NACHA Rule Compliance: Company acknowledges it has a copy or has access to a copy of the Rules. The Rules may also be purchased online at www.nacha.org under the publications tab. Company agrees to comply with and be subject to the Rules of NACHA in existence at the date of this Agreement, and any amendments to these Rules made from time to time. It shall be the responsibility of the Company that the origination of ACH transactions complies with U.S. law, including but is not limited to sanctions enforced by the Office of Foreign Assets Control ("OFAC").

The Originator must agree not to originate entries that violate the laws of the United States: Company agrees not to use or attempt to use the Services (a) to 'engage in any illegal purpose or activity or to violate any applicable law, rule or regulation, (b) to breach any contract or agreement by which Company is bound, (c) to engage in any internet or online gambling transaction, whether or not gambling is legal in any applicable jurisdiction, or (d) to engage in any transaction or activity that is not specifically authorized and permitted by this Agreement. Company acknowledges and agrees that Administrator has no obligation to monitor Company's use of the Services for transactions and activity that is impermissible or prohibited under the terms of this 'Agreement; provided, however, that Administrator reserves the right to decline to execute any transaction or activity that Administrator believes violates the terms of this Agreement.

Right to Sever Contract for Violation of NACHA Rules: Company agrees that Administrator has the right to sever contract should the company be found in breach of NACHA rules or United States law.

Right of Third-Party Sender to audit the Originator's Compliance: Administrator may evaluate Company's transaction activity for the purpose of establishing averages for transaction frequency, amount, returns and adjustments. Administrator may from time-to-time request information from Company in order to evaluate a continuation of the Service to be provided by Administrator hereunder and/or adjustment of any limits set by this Agreement. Company agrees to provide the requested information upon request by Administrator. Company authorizes Administrator to investigate or reinvestigate at any time any information provided by Company in connection with this Agreement or the Service. reviewed by Administrator in an audit of Company. If Company refuses to provide the requested financial information, or if Administrator concludes, in its sole discretion, that the risk of Company is unacceptable, if Company violates this Agreement or the Rules, or if Company refuses to give Administrator access to Company's premises, Administrator may terminate the Service and this agreement according to the provisions hereof.

Name

Title

Signature

Date