SecurityHealth Plan℠

Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

1.800.622.7790 | 715.221.9700
TTY 711
Fax: 715-221-9456

Agency Application

Instructions: Complete this form to apply to be a listed agency with Security Health Plan. Remember to sign and date all pages where it applies. ***Note:*** *this application will not be processed unless completed in full.*

For questions, please call 1-800-622-7790, option 1.

Agency Information

Agency legal name OR broker name if sole proprietor	Agency tax ID number that corresponds to the legal name provided OR Social Security number if sole proprietor
Doing business as (if different than legal name)	Check (✓) appropriate business type: ☐ Partnership ☐ Individual/Sole proprietor ☐ LLC ☐ Corporation ☐ ________________

What geographic area do you cover – list the county(ies)

Headquarters address	City	State	ZIP

Headquarters phone number	Office phone number and extension	Fax number
Principal name	Principal phone number	Principal email address
Licensing coordinator name	Licensing coordinator phone number	Licensing coordinator email address
Primary contact	Primary contact phone number	Primary contact email address

Website address

Does the agency have multiple locations: ☐ Yes ☐ No

If yes, indicate other locations within the Security Health Plan Service Area below:

Location 1 street address	City	State	ZIP
Location 1 phone number	Location 1 fax number		
Location 2 street address	City	State	ZIP
Location 2 phone number	Location 2 fax number		

Agency Additional Information

Explain why you are interested in representing Security Health Plan on behalf of your agency

____

____

Wisconsin Book of Business

What are the top three (3) carriers you use:

1. ____
2. ____
3. ____

How long has the agency been in the health insurance business: Years __________ Months __________

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Security Health Plan will establish an agency production and performance matrix.

Employer Group Products	Check (✓) if Applying to Sell	Current Number of Employers	Anticipated SHP Production (Number of Employers)
Small group			
Large group			
Self-insured			
Consumer Products	**Check (✓) if Applying to Sell**	**Current Number of Contracts**	**Anticipated SHP Production (Number of Contracts)**
Individual and Family Plan (IFP)* or Medicare Supplement			
Medicare Advantage/MSA*			

** Annual production requirement is 12 IFP and/or Medicare contracts*

Agency Qualifications

Check (✓) the appropriate box to answer each question.

Has your agency license ever been suspended, revoked or terminated . . . . ☐ Yes ☐ No

If yes, explain ______________________________

Has the agency ever been cited for a Centers for Medicare and Medicaid Services (CMS) or Office of the Commissioner of Insurance (OCI) violation. . . . . ☐ Yes ☐ No

If yes, explain ______________________________

Is the agency currently involved in an insurance department hearing . . . . ☐ Yes ☐ No

If yes, explain ______________________________

Does your agency have errors and omissions coverage . . . . ☐ Yes ☐ No

A copy of the E & O declaration page or certificate of insurance is required

Has the agency or any of the affiliated agents ever been fined, reprimanded, censured or the subject of a consent decree in Wisconsin or in any state for a violation of its insurance statutes or administrative regulations. . . . . ☐ Yes ☐ No

If yes, explain ______________________________

Has the agency or any of the affiliated agents ever had their license to solicit insurance deferred, suspended, denied or revoked in Wisconsin or any other state. . . . . ☐ Yes ☐ No

If yes, explain ______________________________

Has the agency or any of the affiliated agents ever been convicted of a misdemeanor, felony or other offense which involved circumstances relating to insurance activities . . . . ☐ Yes ☐ No

If yes, explain ______________________________

Has the agency or any of the affiliated agents ever been convicted of a misdemeanor, felony or other offense involving the theft, conversion or misappropriation of funds . . . . ☐ Yes ☐ No

If yes, explain ______________________________

Has anyone ever declined to cover you under a fidelity bond or equivalent bond . . . . ☐ Yes ☐ No

If yes, explain ______________________________

Do you know of any reason why you might not now qualify for bonding coverage. . . . . ☐ Yes ☐ No

If yes, explain ______________________________

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Has your contract or agent listing been terminated or non-renewed by an insurance company because of allegations of misconduct or wrongdoing. . . . . ☐ Yes ☐ No

If yes, explain ____

Do you have any past or present financial difficulties (suits, judgements, bankruptcies, etc.). . . . . ☐ Yes ☐ No

If yes, explain ____

Agency Application

I herby certify that I have read and understand the items on this form and that my answers are true and complete to the best of my knowledge. I have been advised that Security Health Plan of Wisconsin, Inc. may conduct investigations in connection with my request to represent Security Health Plan of Wisconsin, Inc. in the solicitation of Security Health Plan of Wisconsin, Inc. products.

If approved, I agree to represent Security Health Plan so as not to adversely affect the business, good standing or reputation of Security Health Plan.

Subject to Security Health Plan approval, a contracted Security Health Plan agency may list individual agents with Security Health Plan in accordance with the terms and conditions in the Security Health Plan Agency Agreements. Any issued Security Health Plan business written by a listed agent is recorded and credited to the contracted agency, with commissions payable to the contracted agency. The contracted agency is solely responsible for compensation to their agent(s).

I understand that neither I nor brokers of this agency may represent Security Health Plan until notified as appointed with Security Health Plan.

I understand that if any of the information I provide is found to be incorrect or incomplete, it may be grounds for denying my application or my immediate termination at the discretion of Security Health Plan of Wisconsin, Inc.

Failure to complete all information will result in denial of application.

____
Agency principal signature

____ ____________________ ______ /______ /______
Print name Title Date (month/day/year)

Mail, fax or email form to:

Security Health Plan
Sales Department
1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

Fax: 715-221-9456

Email: shpsalessupport@securityhealth.org

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