AGENT CONDITIONS FOR APPOINTMENT

Appointment Application

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

Agency Information:

Agency Name: _____

Agency Address: _____ Telephone: _____

City: _____ County: _____ State: _____ Zip Code: _____

Agent Information:

Agent Name (Last, First Middle): _____ Suffix (Jr., Sr.)

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

Home Address: _____ Telephone: ( ) _____

City: _____ County: _____ State: _____ Zip Code: _____

Correspondence Address: _____ Telephone: _____

City: _____ County: _____ State: _____ Zip Code: _____

Email Address: _____ Fax Number: _____

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

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

Are you currently licensed in the State of Florida to sell health insurance products? ☐ YES ☐ NO
(If you have a non-resident license to sell health insurance products in Florida, check yes)

License #(s) and Description(s):

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

License #	Type of License	State	Company

she

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

1. Have you (or the partners, members, directors, officers, or agents of this company/corporation/partnership) ever been convicted of a crime (whether felony or misdemeanor) other than a minor traffic violation?

   ☐ YES ☐ NO

2. Have you (or the partners, members, directors, officers, or agents of this company/corporation/partnership) ever been fined, reprimanded, sanctioned, or been the subject of a consent decree in any state for a violation of insurance laws, HMO regulations, or other administrative regulations?

   ☐ YES ☐ NO

3. Have you (or the partners, members, directors, officers, or agents of this company/corporation/partnership) ever been refused license to sell Insurance/HMO products, or has a license to sell Insurance/HMO products ever been suspended or revoked by any state?

   ☐ YES ☐ NO

4. Have you (or the partners, members, directors, officers, or agents of this company/corporation/partnership) ever been employed by an Insurance/HMO company, or another organization providing for or assisting with the administration of health care or other employee benefits, where the employment contract was terminated or non-renewed because of allegations of wrongdoing?

   ☐ YES ☐ NO

5. Have you (or the partners, members, directors, officers, or agents of this company/corporation/partnership) ever surrendered any insurance or HMO license, whether voluntary or involuntary?

   ☐ YES ☐ NO

6. Have you (or the partners, members, directors, officers, or agents of this company/corporation/partnership) ever declared bankruptcy, had a lien placed against you or your company, been a judgment debtor, or had other problems with your or your company's credit history?

   ☐ YES ☐ NO

7. Are you (or the partners, members, directors, officers, or agents of this company/corporation/partnership) currently named party in any lawsuit?

   ☐ YES ☐ NO

8. Have you ever been short in accounts with any employer?

   ☐ YES ☐ NO

9. Has an application for bond ever been declined to you?

   ☐ YES ☐ NO

Employment History:

Name of Present / Most Recent Employer: _____ Supervisor:_____

Job Title/Position: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Years of Service: _____ Years & _____ Months

Name of Previous Employer: _____ Supervisor:_____

Job Title/Position: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Years of Service: _____ Years and _____ Months

References:

Please provide the names and addresses of two references (*not relatives*) who have known you for at least one year.

Name: _____ Relationship: _____

Address: _____ Phone Number: _____

Name: _____ Relationship: _____

Address: _____ Phone Number: _____

Language Skills:

Primary Language Written/Spoken/Read: _____

Secondary Language(s) Written/Spoken/Read (list all that apply):

Language (include all that apply)	Dialect, region, or country	Level of Fluency (circle) F=Fluent, M=Moderately Fluent, S=Somewhat Fluent			Do you use this language regularly in your job? (circle)	If you do not use this language regularly in your job, would you be willing to? (circle)
		Speaking	Reading	Writing		
		F M S	F M S	F M S	Yes No	Yes No
		F M S	F M S	F M S	Yes No	Yes No
		F M S	F M S	F M S	Yes No	Yes No

Ethnicity *(optional)*: What Is Your Race/Ethnicity (check one):

____ White (non-Hispanic)

____ Hispanic (Please name your ancestry, i.e., Mexican, Puerto Rican, Cuban, etc.) _____

____ African American ____ Black Caribbean

____ American Indian

____ Asian/Pacific Islander (Please name your ancestry, i.e., Chinese, Japanese, etc.) _____

____ Asian Indian

____ Other (Please name.) _____

PRIVACY AND SECURITY

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

1) Privacy and Security of Protected Health Information.

a) Permitted Uses and Disclosures. Except as otherwise permitted by CHP (hereafter referred to as "Company"), Business Associate may use, disclose, or request the minimum necessary Protected Health Information and Nonpublic Personal Financial Information to perform functions, activities, or services for, or on behalf of, Company as specified in this Agreement, provided that such use, disclosure, or request would not violate the HIPAA-AS Privacy Rule if done by Company.

b) Prohibition on Unauthorized Use or Disclosure. Business Associate shall not use or disclose Protected Health Information or Nonpublic Personal Financial Information other than as permitted or required by Company or as required by law.

c) Information Safeguards and Breach Reporting.

(i) Privacy of Protected Health Information. Business Associate shall use appropriate safeguards to prevent use or disclosure of Protected Health Information and Nonpublic Personal Financial Information not provided for by Company.

Business Associate shall report in writing to Company's Corporate Compliance Office any use or disclosure of Protected Health Information or Nonpublic Personal Financial Information not provided for by Company as soon as practicable but no later than five days after Business Associate becomes aware of the unauthorized use or disclosure. Unless otherwise directed by Company's Corporate Compliance Office, Business Associate shall include in the report the following:

(A) the date of the unauthorized use or disclosure;

(B) the name and (if known) address of the person or entity that received Protected Health Information as a result of the unauthorized disclosure;

(C) a brief description of the Protected Health Information that was the subject of the unauthorized use or disclosure;

(D) a brief statement of the nature of the unauthorized use or disclosure;

(E) the name, date of birth, and contract number of the individual(s) whose Protected Health Information was the subject of the unauthorized use or disclosure;

(F) the corrective action that Business Associate has taken or will take to prevent further unauthorized uses or disclosures; and,

(G) the steps that Business Associate has taken or will take to mitigate any known harmful effects of the unauthorized use or disclosure.

(ii) Security of Electronic Protected Health Information. Business Associate shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic Protected Health Information.

d) Business Associate shall report in writing to Company's Corporate Compliance Office any successful Security Incident as soon as practicable but no later than five days after Business Associate becomes aware of the Security Incident, and shall submit follow-up documentation as directed by Company's Corporate Compliance Office. On Company's request and direction, Business Associate shall report in writing any attempted but unsuccessful Security Incident of which Business Associate becomes aware. Business Associate shall comply with this Section 1(d)(ii) on the effective date of appointment.

e) Mitigation. Business Associate shall mitigate to the extent practicable any harmful effect of which Business Associate is aware that is caused by any use or disclosure of Protected Health Information or Nonpublic Personal Financial Information not provided for by Company.

f) Agents and Subcontractors. Business Associate shall ensure that its agents and subcontractors to whom it provides Protected Health Information agree in writing to the same privacy and security restrictions and conditions that apply to Business Associate with respect to that information.

g) Business Associate Guidance. Business Associate shall comply with any policy, procedure, or guidance with respect to Business Associate's responsibilities under Sections E that Company may, from time to time, issue and communicate in writing to Business Associate.

2) Management of Protected Health Information.

a) Access. Business Associate shall, within seven days following Company's request, make available to Company for inspection and copying Protected Health Information about an individual that is in Business Associate's custody or control, so that Company may meet its access obligations under the HIPAA-AS Privacy Rule.

b) Amendment. Business Associate shall, within 14 days following Company's request, amend or permit Company to amend any portion of Protected Health Information that is in Business Associate's custody or control so that Company may meet its amendment obligations under the HIPAA-AS Privacy Rule.

c) Disclosure Accounting. Business Associate shall record the information specified below ("disclosure information") for each disclosure of Protected Health Information that Business Associate makes, excluding disclosures identified in 45 CFR § 164.528(a)(1) including, but not limited to, disclosures for Treatment, Payment, and Health Care Operations and disclosures under a HIPAA-AS compliant authorization, and shall report the disclosure information in writing to Company's Corporate Compliance Office at P.O. Box 15349, Tallahassee, Florida, 32317-5349 within five days of Business Associate making the accountable disclosure. Disclosure information shall include:

(i) the disclosure date;

(ii) the name and (if known) address of the person or entity to which Business Associate made the disclosure;

(iii) a brief description of the Protected Health Information disclosed;

(iv) a brief statement of the purpose of the disclosure;

(v) the name and date of birth of the individual whose Protected Health Information was disclosed; and,

(vi) that individual's contract number.

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

e) Breach of Privacy and Security Obligations.

f) Termination. Company and Business Associate specifically acknowledge and agree that a breach of any term of the "Privacy & Security" subsection of the Conditions for Appointment (the "Subsection") shall be considered a breach of a material term of the Conditions, and Company may terminate the Agent's appointment.

g) Obligations on Termination.

(i) Return or Destruction of Protected Health Information. On termination of the Agent's appointment, Business Associate shall, if feasible, return to Company or destroy all Protected Health Information in its custody or control in whatever form or medium, including all copies and all derivative data, compilations, and other works that allow identification of any individual who is a subject of the Protected Health Information. Business Associate shall identify to Company in writing any Protected Health Information that cannot feasibly be returned to Company or destroyed, and explain why return or destruction is infeasible. Business Associate shall limit further use or disclosure of the Protected Health Information to those purposes that make its return or destruction infeasible. Business Associate shall complete these obligations as promptly as possible, but not later than 30 days following the effective date of the termination of the Agent's appointment.

(ii) Continuing Privacy and Security Obligations. Business Associate's obligation to protect the privacy and confidentiality and safeguard the security of Protected Health Information as specified in the Conditions shall be continuous and survive termination of the Agent's appointment.

3) General Provisions for the Subsection.

a) Definitions. The terms "Electronic Protected Health Information" and "Protected Health Information" have the meanings set out in 45 CFR § 160.103, except Protected Health Information shall be limited to that information created or received by Business Associate from or on behalf of Company. The term "Required by Law" has the meaning set out in 45 CFR § 164.103. The term "Security Incident" has the meaning set out in 45 CFR § 164.304. The terms "Health Care Operations," "Payment," and "Treatment" have the meanings set out in 45 CFR § 164.501. For purposes of this Addendum, Protected Health Information encompasses Company's Electronic Protected Health Information. The term "Nonpublic Personal Financial Information" has the meaning set out in Fla. Admin. Code § 4-128.002 except Nonpublic Personal Financial Information shall be limited to that information created or received by Business Associate from or on behalf of Company.

b) Amendment to the Subsection. The Subsection automatically shall amend on the compliance date of any final regulation or amendment to final regulation promulgated by HHS or a Florida regulatory agency concerning the subject matter of the Subsection such that Business Associate's obligations remain in compliance with the final regulation or amendment to final regulation, unless Company or Business Associate elects to terminate Section E by giving the other party written notice of termination at least 90 days before the compliance date of the final regulation or amendment to final regulation.

c) No Third Party Beneficiaries. No party shall be deemed a third party beneficiary of the Subsection.

GOOD STANDING CRITERIA

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

1) Comply with the Conditions for Appointment.

2) Comply with all CHP corporate policies and procedures.

3) Have a valid Florida resident health and life agent license.

she

4) Have on file with Company a fully executed Conditions for Appointment form.

5) Provide evidence that all continuing education credits/coursework requirements have been and continue to be met.

COMMISSIONS

CHP shall pay Agents a commission for new sales and renewals, based on the CHP commission schedule and formulas in effect at the time of payment. The commission statement issued with the payment will record the method of calculation. Agent agrees to accept commission payment by ACH (Automated Clearing House.)

PAYMENT FOR AGENT APPOINTMENT FEES

1) Company will pay for statutory Appointment fees when:

a) Agent meets all Good Standing Criteria.

b) Agent has active inventory of a minimum of 100 Contracts, which inventory will be evaluated.

i. At the end of the initial 12 month period calculated from the date of appointment; and

ii. At the end of every subsequent twelve (12) month period thereafter.

2) If the Appointed Agent satisfies this minimum inventory standard, Company will pay to renew their Appointment; however,

a) If at any time the Appointed Agent does not satisfy the minimum inventory standard, or the Agent's Appointment is terminated by the State of Florida for any reason, the Appointed Agent may be required to reimburse Company for the Appointment Fees that Company paid on the Agent's behalf.

b) If the Appointed Agent fails to reimburse Company or submit renewal Appointment Fees, Company shall, within 30 calendar days from the date that Agent was notified to reimburse Company, terminate the Appointed Agent's Appointment and cease commission payment(s) to the Designated Producer.

CHP will be obtaining a complete list of companies with which you hold a current agent appointment as listed on the State of Florida Office of Insurance Regulation (OIR) website.

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

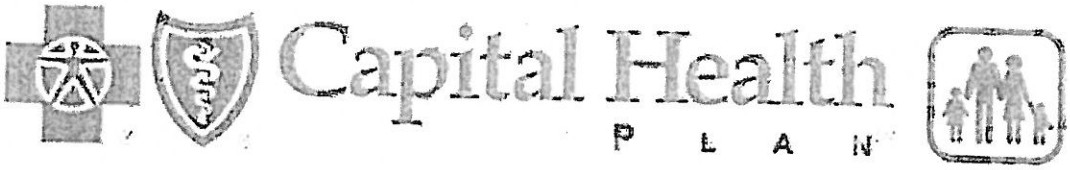
NOTICE: "The Fair Credit Reporting Act" requires that we advise you that a routine inquiry may be made during our initial or subsequent processing of your application for sponsorship for license that will provide applicable information concerning your health, past history, character, general reputation, personal characteristics, and mode of living. The information obtained in this inquiry may be released

to any third party, including state and federal regulatory bodies. On your written request, additional information about the nature and scope of the inquiry, if one is made, will be provided.

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

Signature of Applicant: _____

Date: _____



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

We have attached for your completion a standardized letter that includes the information we need most when processing an invoice for payment or needing a direct contact regarding the status of our account.

Please take a moment to complete the vendor information profile in the form and fashion requested and fax the completed form along with your most current IRS Form W-9 to the attention of our Accounts Payable Department at (850) 383-3441. As a follow-up, we are asking that the original signed information request and W-9 be mailed to the address below:

Capital Health Plan
Attn: Accounts Payable Department
P.O. Box 15349
Tallahassee, FL 32317-5349

We sincerely appreciate your prompt attention to this request.

(PLEASE PROVIDE THIS INFORMATION ON YOUR COMPANY LETTERHEAD)

(CURRENT DATE)

Capital Health Plan
Accounts Payable
2140 Centerville Place
Tallahassee, FL 32308

Reference: Vendor Profile

To Capital Health Plan:

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

MAILING ADDRESS: STREET_____
CITY _____
STATE _____ZIP CODE_____

A/P REMIT ADDRESS: STREET_____
CITY _____
STATE _____ZIP CODE_____

TELEPHONE NO.: _____ FAX NO.: _____

FEID NO. _____

BUSINESS ENTITY TYPE (PROPRIETORSHIP, PARTNERSHIP, CORPORATION)

ACCOUNTING DEPARTMENT CONTACT:
NAME:_____
TITLE:_____
TELEPHONE NUMBER:_____

PRIMARY BUSINESS PURPOSE: _____

Sincerely,

NAME
TITLE

Form **W-9**
(Rev. August 2013)
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.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:
☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

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

☐ Other (see instructions) ▶

Exemptions (see instructions):
Exempt payee code (if any) _____
Exemption from FATCA reporting code (if any) _____

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

Requester's name and address (optional)

City, state, and ZIP code

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 the "Name" line to avoid backup withholding. For individuals, this is 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 chart on page 4 for guidelines on whose number to enter.

Social security number
☐☐☐ - ☐☐ - ☐☐☐☐

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. The IRS has created a page on IRS.gov for information about Form W-9, at *www.irs.gov/w9*. Information about any future developments affecting Form W-9 (such as legislation enacted after we release it) will be posted on that page.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, payments made to you in settlement of payment card and third party network transactions, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

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.

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.

Capital Health PLAN℠

An Independent Licensee of the Blue Cross and Blue Shield Association

ACH ENROLLMENT & AUTHORIZATION FORM

Vendor

Account Status: ☐ Set up New Account ☐ Change Account profile

Name:_____ FED Number_____
(please print)

BANK INFORMATION

Financial Institution_____ Branch_____

Transit/ABA No._____ Account No._____

Checking_____Savings_____
(please check one above)

ATTACHED VERIFICATION OF BANK ACCOUNT AND ROUTING INFORMATION

APPROVAL

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

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

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

Signature_____ Date_____

Contact
Name:_____ E-Mail Address:_____ Telephone No:_____

THIS SECTION WILL BE COMPLETED BY CHP ACCOUNTS PAYABLE DEPARTMENT

Date Received: _____ Date Entered: _____
month/day/year *month/day/year*

Entered by: _____

Approved by: _____

ADDENDUM TO THE
BUSINESS ASSOCIATE AGREEMENT
BETWEEN
CAPITAL HEALTH PLAN, INC.
AND BUSINESS ASSOCIATE / SUB CONTRACTOR

Due to a new State of Florida requirement, effective June 28, 2016, The Business Associate Agreement by and between Capital Health Plan, Inc. ("CHP") (The "Covered Entity") and any and all Business Associates and Subcontractors (the "Business Associate") doing business on behalf of Capital Health Plan for the State of Florida has been amended as follows:

> "2.16 Pursuant to section 20.055(5), Florida Statute, Business Associate understands and agrees to cooperate with the Department of Management Service's inspector general in any investigation, audit, inspection, review, or hearing pursuant to this section."

All other terms and conditions within the Business Associate Agreement shall remain unchanged.

Revision History:

QIMT - Approved: 06/30/2016; Compliance Committee Approved: 08/23/16
Reviewed - No Changes:
Revised:
Policy Location (s): Compliance Intranet – Compliance Forms

BUSINESS ASSOCIATE AGREEMENT

This agreement is entered into this _ day of ____, _____, by and between Capital Health Plan, Inc., a Florida corporation not for profit ("CHP"), and _ ("Business Associate").

RECITALS

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

2. Business Associate is engaged to render _____ to CHP ("Services") as and when requested by CHP's management, and is a "business associate" as defined in the Privacy Rule and the Security Rule. From time to time, it may be necessary to the rendition of such services that Business Associate have access to protected health information relating to CHP members.

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

STATEMENT OF AGREEMENT

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

SECTION 1. Definitions.

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

Business Associate. "Business Associate" shall mean _____.
Breach. "Breach" shall have the same meaning as the term "breach" in Sections 13400(1) and 13402 of the HITECH Act and 45 CFR §164.402.
Covered Entity. "Covered Entity" shall mean CHP.
HITECH Act. "HITECH Act" shall mean the Health Information Technology for Economic and Clinical Health Act, enacted as Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009, P.L. 111-5. All references in this

Dear Agents,

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

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

All Small Group renewals will be posted to CHP*Connect*.

In order to pick up your renewals, please register for CHP*Connect* today by following these five simple steps below:

1. Access our website: www.capitalhealth.com
2. Click the pink "**Employers/Agents**" link.
3. Click the "**Account Resources**" link.
4. Click the "**CHP*Connect*: Employers & Administrators**" link.
5. Click the "**CHP*Connect***" link.
6. Click the "**Broker**" icon found under ***New Users.***
7. Follow registration prompts.
8. Sign & return the CHP User Agreement to Stacey Hammond at slhammond2@chp.org.

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

Remember, it is necessary for you to register for CHP*Connect* in order to receive your client renewals.

Thank you for your continuous support of Capital Health plan. We look forward to seeing you on CHP*Connect*!

Sincerely,

Stacey Hammond
Group Service Representative
Capital Health Plan, Sales
(850) 523-7477

CHP*Connect*

Broker/ Agent and Agency Agreement

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

_____	_____	(___)_____
Print User Name	Agency Name	Contact Phone
_____	_____	
User Signature	Date	

Check (✓) the User Profile Required for this User

Check (✓) if Applicable	Access List	Functions
Broker Admin ☐	Only list the name(s) of the Capital Health Plan **appointed Agent(s)** for whom the above User will be accessing files for. **NOTE: THIS IS NOT A LIST OF USERS** 1)._____ 2)._____ 3)._____ 4)._____	Add Site Users; Access Group Renewals, Reports; Submit New Group Quote Request; Submit Group Renewal Contract; Access Quarter Rates; View Member Eligibility and Demographics; View Employer Monthly Billing Statement, etc. NOTE: While the User may also be the appointed Agent with Capital Health Plan, one User cannot give access to another User. Each User must read and sign their own individual User Agreement.
Broker FTA ☐	List the Agency Name on file at Capital Health Plan 1)._____	View Commissions and Commission Statements

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

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

This is a reminder that you will be assigned the Administrative role in CHPC*onnect*.

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

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

Always Remember:

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

If you have any questions or would like to discuss this further, please contact me at 850-523-7477 or by email, slhammond2@chp.org.

Thank you,

Stacey Hammond
Capital Health Plan, Account Executive

Agreement to such Act or to any section thereof shall be deemed to include all applicable regulations and guidance as may be promulgated or issued, respectively, to implement such Act.

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

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

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

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

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

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

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

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

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

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

SECTION 2. Obligations and Activities of Business Associate

Business Associate agrees to the following:

a. **Not to Use or Disclose PHI Unless Permitted or Required.** Business Associate agrees to not request, use, or disclose Protected Health Information other than as permitted or required by the Agreement, or as Required by Law, or as otherwise authorized by CHP. Business Associate may use or disclose Protected Health Information only if such use or disclosure, respectively:
   (i) is in full compliance with each applicable requirement of Section 164.504(e) of Title 45, Code of Federal Regulations, and
   (ii) would not violate the Privacy Rule if made by CHP.

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

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

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

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

f. **Provide Access.** Business Associate agrees to provide access, during normal business hours, to Protected Health Information in a Designated Record Set of CHP to CHP in order to meet the requirements of 45 CFR §164.524, provided

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

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

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

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

j. **Restrictions on Disclosures.** If Business Associate receives from any Individual a request to restrict uses or disclosures of an Individual's Protected Health Information, Business Associate will promptly notify CHP of such request. Business Associate will comply with directions from CHP to restrict the use or disclosure of

Protected Health Information for an Individual if CHP advises Business Associate that CHP must comply with such restrictions as required by Section 13405 of the HITECH Act and 45 CFR §164.522(a)(1)(vi).

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

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

m. **Hold Harmless.** Business Associate shall indemnify CHP and hold CHP
    a. harmless for and from any loss or liability, including without limitation civil money penalties, suffered or incurred by CHP, in the event CHP becomes vicariously liable for the actions or inactions of Business Associate in the circumstance described by 45 CFR §160.402(c)(1), and without any fault on the part of CHP. This provision shall not be construed or interpreted to limit any other duty or liability Business Associate may have to CHP under applicable law.

SECTION 3. ***Permitted Uses and Disclosures by Business Associate***

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

SECTION 4. Obligations of CHP

a. **Notice of Privacy Practices.** CHP shall notify Business Associate of any limitation(s) in its notice of privacy practices of CHP in accordance with 45 CFR §164.520, to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information.

b. **Notice of Changes in Permission.** CHP shall notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes may affect Business Associate's use or disclosure of Protected Health Information.

c. **Notice of Other Restrictions.** CHP shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that CHP is required to honor pursuant to the HITECH Act, or that CHP has agreed to in accordance with 45 CFR §164.522, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.

SECTION 5. Term and Termination

a. **Term.** The Term of this Agreement shall be effective as of April 14, 2003, or the date upon which Business Associate is first engaged to provide Services to CHP, whichever is later, and shall terminate when all of the Protected Health Information created, received, or maintained by Business Associate from or on behalf of CHP, is destroyed or returned to CHP, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section.

b. **Termination for Cause.** Upon CHP's reasonable determination of a material violation of this agreement by Business Associate, CHP shall give written notice of such violation to Business Associate and either:
Provide an opportunity for Business Associate to cure or end the violation,
as appropriate in CHP's reasonable judgment, and terminate this Agreement if Business Associate does not cure or end the violation within the time specified by CHP; Immediately terminate this Agreement if Business Associate has violated material term of this Agreement, termination is feasible, and cure is not possible.

c. **Effect of Termination.**

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

i. In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to CHP notification of the conditions that make return or destruction infeasible. Upon notice that return or destruction of

Protected Health Information is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

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

SECTION 6. Miscellaneous

a. **Regulatory References.** A reference in this Agreement to a section in the Privacy Rule or the Security Rule means the section as in effect or as amended.

b. **Amendment.** The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for CHP to comply with the requirements of the Privacy Rule, the Security Rule, the HITECH Act, and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, as they may be amended from time to time.

c. **Survival.** The respective rights and obligations of Business Associate under Section 5(c) of this Agreement shall survive the termination of this Agreement.

d. **Interpretation.** Any ambiguity in this Agreement shall be resolved to permit CHP to comply with the Privacy Rule, the Security Rule, and other applicable law governing the privacy and security of health information. IN WITNESS WHEREOF, the parties have executed and delivered this Agreement on the date first above written.

CAPITAL HEALTH PLAN, INC.

BY: _____
Kathleen Jugenheimer

As its: *Compliance and Privacy Officer*

Email Address:

kajugenheimer@chp.org

Mailing Address:
Capital Health Plan
Post Office Box 15349
Tallahassee, Florida 32317

_____
(Business Associate)

By:_____
Signature

_____
Printed Name

As its: _____

Email Address:

_____

Mailing Address:

_____
Company Name

_____
Street Name

_____
Post Office Box

_____
City

_____
State

_____
Zip Code

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