

PRODUCER COMPENSATION AGREEMENT



Effective as of the date signed below, ALLIED NATIONAL, LLC, 4551 W. 107th St., Overland Park, KS 66207 ("ALLIED"), a Third Party Administrator for insurance companies that underwrite the insurance coverage referenced below ("INSURANCE"), and for the level-funded employer ERISA plans (including Stop-Loss insurance coverage) referenced below ("ERISA PLANS"), and the Producer named below ("PRODUCER"), in consideration of the following promises and covenants, AGREE AS FOLLOWS:

1. PRODUCER may submit to ALLIED applications for INSURANCE and/or enrollments for ERISA PLANS. PRODUCER will receive, as full compensation, commissions for the INSURANCE, and consulting fees for the ERISA PLANS, as provided in the attached Schedule of Compensation ("COMPENSATION").
2. PRODUCER has no authority to make or alter the INSURANCE or ERISA PLANS, or any policy, certificate, plan document or summary plan description ("SPD") thereof, including any term, provision, obligation or condition, or to extend the time of payment for monthly premiums, contributions or other charges, or to receive said payments (unless submitted with new business). Any such payments received by PRODUCER shall be promptly submitted (or paid) to ALLIED.
3. PRODUCER shall not place applications for INSURANCE and/or enrollments for ERISA PLANS until and unless properly licensed (and appointed, if required) by law.
4. COMPENSATION shall be payable to PRODUCER (or its legal representative) for any INSURANCE or ERISA PLAN submitted to ALLIED by PRODUCER. COMPENSATION may be modified by ALLIED, for either new or existing INSURANCE or ERISA PLANS, at any time upon written notice to PRODUCER. No assignment of COMPENSATION (earned or accrued, or to be earned or accrued) shall be binding upon ALLIED without its written consent.
5. COMPENSATION shall be payable to PRODUCER with respect to any INSURANCE or ERISA PLAN submitted to ALLIED by PRODUCER, unless ALLIED receives written notice from the insurance company, or the participating or sponsoring employer, or the insured, that PRODUCER is no longer authorized to act as their agent.
6. If for any reason coverage under any INSURANCE or ERISA PLAN for which PRODUCER has received COMPENSATION is rescinded, terminated retroactively, terminated early, delayed or otherwise modified, or premiums or contributions are reformed or otherwise adjusted, PRODUCER hereby agrees to reimburse ALLIED for any and all excess COMPENSATION due to such modification or adjustment.
7. ALLIED may, at any time, deduct from any COMPENSATION due PRODUCER, any indebtedness of PRODUCER to an insurance company or ALLIED, together with interest at the maximum legal rate and any collection costs.
8. This Agreement may be terminated for cause by ALLIED upon written notice to PRODUCER, if PRODUCER:
 - a) withholds any INSURANCE or ERISA PLAN monthly premiums, contributions or other charges, or excess COMPENSATION, whether due the insurance company, ERISA PLAN or ALLIED;
 - b) fails to comply with applicable law or regulation, or any policy or procedure of ALLIED or an insurance company;
 - c) knowingly misrepresents any INSURANCE or ERISA PLAN, or other product or service offered through ALLIED;
 - d) knowingly or negligently fails to comply with a material term of this Agreement in any manner;
 - e) defrauds or attempts to defraud ALLIED, a ERISA PLAN or an insurance company;
 - f) has any required license revoked or non-renewed;
 - g) uses any advertising materials not authorized by ALLIED, a ERISA PLAN or an insurance company;
 - h) knowingly furnishes false information, or fails to disclose information, of a material nature to ALLIED; or
 - i) dies, or is dissolved, liquidated or sold, but such termination will be no sooner than one year following the event.
9. If this Agreement is terminated for cause by ALLIED, PRODUCER shall not be entitled to any COMPENSATION which would otherwise be payable under this Agreement, including renewal COMPENSATION, effective as of the date of termination. Either party may terminate this Agreement without cause upon 10 days written notice to the other party.
10. This Agreement constitutes the entire contract between the parties hereto. Any amendment to this Agreement shall be in writing, effective as of the date executed by ALLIED.
11. ALLIED retains the right to decline acceptance of any application or enrollment form, to change or withdraw any insurance certificate or SPD, to decline to administer a level-funded plan or to change or discontinue any product or service at any time.
12. PRODUCER acknowledges it may receive certain non-public, personal information of individuals covered by the INSURANCE and ERISA PLANS ("CLIENTS") administered by ALLIED. PRODUCER:
 - a) shall securely and privately maintain the confidentiality of all non-public, personal information of CLIENTS ("CLIENT INFORMATION") pursuant to applicable state and federal privacy laws and regulations;
 - b) covenants and agrees not to use, disclose or in any manner reveal CLIENT INFORMATION other than as necessary for INSURANCE or ERISA PLAN administration purposes contemplated by this Agreement, including effecting or administering transactions on behalf of and requested by CLIENTS, or to comply with applicable laws or regulations; and
 - c) shall defend, indemnify and hold ALLIED harmless from all loss, costs, judgments, settlements, fines, assessments, penalties or other monetary expenditures, including reasonable attorney fees, incurred by ALLIED, as a direct or indirect result of a violation by PRODUCER of this paragraph 12 of this Agreement.
13. PRODUCER hereby authorizes and consents to receipt of communications from ALLIED for all purposes as contemplated by and during the term of this Agreement, whether by phone, fax, email, direct mail or any other form of communication.

PRODUCER SIGNATURE: X _____ Title: _____ Date: _____

PRODUCER NAME: (Please Print) _____ SSN or Tax ID# _____

ALLIED SIGNATURE: X _____ Title: _____ Date: _____

Allied National, LLC

Return to: Allied National, LLC • PO Box 29187 • Shawnee Mission, KS 66201-9187

AGENT SCHEDULE OF COMPENSATION

For all business effective, and renewing, on or after 8/1/20



Commissions are paid only on earned insurance premium for fully insured plans. Service Fee compensation is paid on level-funded plans.

For all plans: Compensation is not paid on any fee, including but not limited to, PPO fees, Administrative fees, fees paid to outside vendors, taxes and fees imposed by the Affordable Care Act.

No compensation or commission is paid on plan participants being direct billed under COBRA or similar state continuation plans. Group size is determined by number of lives at time of issue or renewal.

Level-Funded Plan Compensation

Product(s)	Group Size	Default First Year and Renewal *
Funding Advantage	2 – 24	6% of maximum monthly cost
	25 – 50	5% of maximum monthly cost
	51 – 100	4% of maximum monthly cost
	101 – 150	3% of maximum monthly cost
	151+	2.5% of maximum monthly cost
Cost Saver	All Groups	10% of maximum monthly costs
MEC	All Groups	10% of maximum monthly costs
Fundamental Care	All Groups	10% of maximum monthly costs

*This is the default compensation amount and may be varied based on agreement between the agent and the employer. Note: Compensation on level-funded plans is not payable on non-standard claim fund contributions (e.g. specific Stop-Loss layers or for benefits paid outside of the SPD contract). Compensation is based on the maximum monthly cost calculated for a group, regardless of plan funding option chosen. The dollar value of the compensation is then recalculated to a percentage of the regular monthly billed amount for the group (based on funding option).

Coverage Type	Group Size	First Year	Renewals
Allied Dental Design (includes vision)	All Size Groups	8%	8%

Pivot Health Short Term & Bridge to Medicare	First Year	Renewal
All States except noted below	15%*	Not Applicable
IA, IN, MS, ND, NE, TN	11%*	Not Applicable
DE, NH, VA	10%*	Not Applicable
MN	7%*	Not Applicable

Short Term Medical Bonus: Comp and bonus for Short Term and Bridge to Medicare plans. Any month in which your commission statement includes ten (10) months of commissionable premium for these plans, a bonus of 5% of premium will be paid.

Other Pivot Health Products	First Year	Second Year	Third Year & Later
PivotCare Elite	25%	7%	3%
PivotCare Economy	25%	7%	3%
PivotCare Economy (TN & OH)	20%	2%	2%
PivotCare Economy (NM)	15%	3%	3%
Pivot Health Renaissance Dental	10%	10%	10%

AGT# _____

Direct Deposit Authorization Form

This authorizes Allied National to send credit entries (and appropriate debit and adjustment entries) electronically, or by any other commercially accepted method, to my (our) account indicated below and to other accounts I (we) identify in the future (the "Account"). This authorizes the financial institution holding the Account to post all such entries.

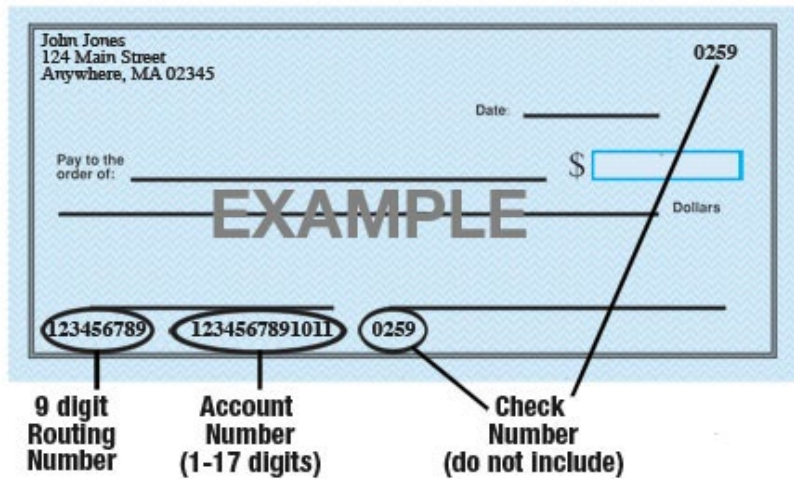
Please print and complete **ALL** information below.

Individual Name or Agency Name: _____

Address: _____

City, State, Zip: _____

Email: _____



Name of Bank: _____

9-Digit Routing #: _____

Account #: _____

Type of Account: Checking Savings (Check One)

You may attach a voided check for the bank account to which funds should be deposited.

Allied National is hereby authorized to directly deposit my check to the account listed above. This authorization will remain in effect until Allied National has received a written termination notice.

Authorized Signature: _____

Print Name/Title (if applicable): _____

Date: _____