

NexBenefit Insurance Services (NIS)

P.O. Box 2126 ♦ Castro Valley, CA 94546 ♦ Phone: (800) 858-0355 ♦ Fax: (877) 359-0716
Website: www.NexBenefit.com

Online Contract Questionnaire

FIRST NAME _____ MI _____ LAST NAME _____

SSN _____ DOB _____ E-MAIL ADDRESS _____

AGENCY NAME _____ TAX ID _____

BUSINESS ADDRESS _____

UPS ADDRESS _____

HOME ADDRESS _____

BUSINESS PHONE _____ FAX NUMBER _____

CELL PHONE _____ HOME PHONE _____

Are you working under another agent or agency? If so, please specify:

Please select the companies that you would like to contract with or transfer your existing contract with:

LONG-TERM CARE

- Life Secure
- John Hancock
- Mutual of Omaha

DISABILITY

- Mutual of Omaha
- MetLife

CRITICAL ILLNESS

- MetLife
- Mutual of Omaha

Please fax the following along with these two pages to (877) 359-0716:

- License (Resident and Non-Resident)
- E & O coverage page
- Void check for EFT (Carrier requirement)
- LTC CE
- Partnership Certification

Are you submitting business? YES NO - If yes. App Date: _____ State: _____ Carrier _____

BACKGROUND **IMPORTANT**** Please read carefully and sign**

If you have any background issues regarding bankruptcy, debt to insurance companies, misdemeanors, felonies, crime convictions, judgments or liens, regulatory actions, company appointment terminations, or license suspensions or revoked, if you have been or currently are an agent or if any immediate family members are contracted with the companies you are applying for, please include a detailed explanation on a separate page.

NexBenefit Insurance Service has my permission to contract me with the companies I have checked above. I understand that I can request to receive a copy of the entire contract. I also understand that in order for my contracting to be valid, I must return the attached signature page to NexBenefit Insurance Service.

Signature of Agent or Agency

Date

NexBenefit use only
USER ID _____ PASSWORD _____ PIN _____

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Name:

General Agent: NexBenefit Insurance Services (NIS)

I _____ hereby authorize American Independent Marketing to affix or append a facsimile of my signature, as set forth below, to all required signature fields on all Insurance Carrier documents for which I have authorized American Independent Marketing to submit on my behalf, for the purposes of being Contracted to sell products of Carriers through American Independent Marketing.

I affirm that the information I have submitted through the interview process to American Independent Marketing is correct to the best of my knowledge and acknowledge that I have read and reviewed the documents for which I am authorizing my signature to be affixed to. I acknowledge and agree to indemnify and hold harmless any third party from and against any and all loss arising out of its reliance and acceptance of a facsimile of my signature.

Please sign in the center of the box below

Place Voided Check Below to Fax

NexBenefit use only
USER ID _____

PASSWORD _____

PIN _____