Guaranteed Cost Client and Benefit Advisor Acknowledgement Form

Insured Medical: Guaranteed Cost along with Dental, Vision, and Stop-Loss sold with Guaranteed Cost
Insured by one or more of the insurance and/or HMO subsidiaries of Cigna Corporation (collectively "Cigna")

Acknowledgement of Benefit Advisor Designation

Account (number) ________________________________, Client (name) ____

hereby acknowledges that the individual/firm listed below has been designated by Client as its broker of record/consultant ("**Benefit Advisor**") as of: _________________.

Client shall promptly notify Cigna of a change in the Benefit Advisor designation. Benefit Advisor changes are effective the first of the month following the month in which notification is received by Cigna.

Confirmation of Benefit Advisor Compensation

Client has engaged the Benefit Advisor to perform agreed upon services exclusively for the benefit of Client and not Cigna regarding the purchase of group medical insurance coverage (the **"Services"**). Client has agreed to pay the Benefit Advisor as indicated in the Fee Details below for the performance of the Services (the **"Benefit Advisor Fees"**).

(Premium or membership attributable to individuals covered under state continuation laws will not be used in calculating the Benefit Advisor Fees.)

Client shall promptly notify Cigna of any change in the Benefit Advisor Fees.

Client and Benefit Advisor acknowledge that the Benefit Advisor Fees are:

- exclusively for the performance of the Services by the Benefit Advisor;
- not consideration for insurance under the Policy;
- not determined by Cigna; and
- the sole obligation of Client.

Authorizations/Additional Acknowledgements

Client and Benefit Advisor authorize Cigna to:

- Bill, on behalf of the Benefit Advisor, the applicable Benefit Advisor Fees with its monthly premium billing statement to the Client (Benefit Advisor Fees will be reflected in the total amount billed);
- Remit, on behalf of the Client, any Benefit Advisor Fee payments received from the Client to the Benefit Advisor within 60 business days of receipt (Note: Unless the client specifically directs that a portion of its payment be applied to Benefit Advisor Fees, any payments received by Cigna will first be applied toward any outstanding insurance premium and will not be prorated between premium and Benefit Advisor Fees); and
- Attempt, on behalf of the Client, to recover overpayments made to the Benefit Advisor; however, Cigna shall not be responsible to the client for any uncollected amount.

Client authorizes:

- Cigna, as its agent pursuant to Treas. Reg. 1.6041-1(e)(4), to directly file tax information returns (Form 1099-MISC) on its behalf for Benefit Advisor Fees remitted to the Benefit Advisor
- Cigna, as its agent, to withhold and deposit federal income taxes on the Benefit Advisor Fees subject to backup withholding under Section 3406 of the Internal Revenue Code using Cigna's own name and federal employer identification number.
- Cigna, as its agent, to contract with third parties to perform these authorized services, which contract may authorize IRS to disclose confidential tax information of the Client and Cigna to such third party.
- The IRS to disclose confidential tax information to Cigna relating to the authority granted above.

Client and Benefit Advisor further acknowledge that:

- Cigna shall have no obligations with respect to the billing and remittance of the Benefit Advisor Fees other than as set forth above; and
- Such obligations shall terminate when the Policy terminates, the Benefit Advisor ceases to represent the Client, Client and/or Benefit Advisor revoke the foregoing authorizations, or the date specified by Cigna when Cigna notifies Client and Benefit Advisor that it will cease billing and remitting the Benefit Advisor Fees.

Client and/or Benefit Advisor may revoke these authorizations at any time by giving 30 days' prior written notice to Cigna. Client acknowledges that in the event of such revocation, it will thereafter be responsible for the payment of all Benefit Advisor Fees and the performance of the tax information reporting and backup withholding with respect to the Benefit Advisor Fees.

Additional Terms

This document constitutes the entire understanding and agreement of the parties and supersedes any prior agreement or understanding with respect to the subject matter thereof. The terms of this document can only be changed or waived by the mutual, written consent of the Client, the Benefit Advisor and Cigna.

Note: No compensation will be paid to the Benefit Advisor with respect to insurance coverage unless the Benefit Advisor (individual and agency) has a contract with Cigna, holds an appropriate resident or non-resident license and is appointed with Cigna.

"Cigna" is a registered service mark and the "Tree of Life" logo is a service mark of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided exclusively by such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company (CGLIC), Cigna Health and Life Insurance Company (CHLIC), and HMO or service company subsidiaries of Cigna Health Corporation, HealthSpring, Inc. and Cigna Dental Health, Inc.

COMPENSATION DETAILS

Client Name:						Client Situs State:
Product	**Commission Effective Date**	**Per Employee**	**Employee Plus 1/ Spouse**	**Employee Plus 2/ Child**	**Employee Plus 3/ Family**	**Percentage of Premium**

By signing below, you are confirming that you have agreed to the preceding terms and the Compensation Details outlined above.

CLIENT INFORMATION

Signer Name *(Print)*:

Authorized Client Signature:	Date:

WRITING PRODUCER/BENEFIT ADVISOR INFORMATION

Writing Producer Name *(Print)*:	Last 4 digits of SSN or full Tax ID:	Percentage of Compensation:

Authorized Agent or Writing Producer Signature:	Date:

By signing this document, I confirm that the person listed as the Writing Producer solicited, sold and/or negotiated the contract for this account and is properly licensed under applicable state regulations and appointed with Cigna to do so.

Compensation made payable to:

Individual/Agency Name *(Print)*:	Benefit Advisor/Agency Account Number:

Compensation Mailing Address *(Street/P.O. Box)*: *(City)*: *(State)*: *(Zip Code)*:

Last 4 digits of SSN or full Tax ID:	Phone Number:	Email Address:

GENERAL AGENCY INFORMATION *(if applicable)*

General Agency Name *(Print)*:	General Agency Account Number:

General Agency Mailing Address *(Street/P.O. Box)*: *(City)*: *(State)*: *(Zip Code)*:

Sub-Agent if different than Writing Producer *(Print)*:

Authorized Agent of General Agent or Sub-Agent Signature:	Date:

SERVICE PROVIDER INFORMATION *(if applicable)*

Exchange Service Provider Name *(Print)*:	Account Number:
Exchange Service Provider Mailing Address *(Street/P.O. Box)*: *(City)*: *(State)*: *(Zip Code)*:	
Authorized Agent Signature:	Date:

COMPLETE IF MORE THAN ONE PRODUCER

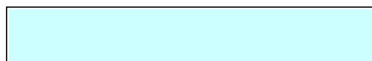
Client Name:

Writing Producer Name *(Print)*:	Percentage of Compensation:
Authorized Agent or Writing Producer Signature:	Date:

Checks made payable to:

Individual/Agency Name *(Print)*:	Benefit Advisor/Agency Account Number:
Compensation Mailing Address *(Street/P.O. Box)*: *(City)*: *(State)*: *(Zip Code)*:	

Last 4 digits of SSN or full Tax ID:	Phone Number:	Email Address:



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