



**CLARENDON NATIONAL ~ AGENT LICENSE REQUEST & HPA, INC. STATEMENT OF UNDERSTANDING FORM**

**COMPLETE THE FOLLOWING INFORMATION ABOUT YOURSELF**

Agent Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Corporation/Agency Name: \_\_\_\_\_ Tax I.D. #: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
Business Street Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_  
Resident Street Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_  
Business Telephone: \_\_\_\_\_ Fax #: \_\_\_\_\_ Resident Telephone: \_\_\_\_\_  
UPS Delivery Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

\* If Commissions are to be paid to an Agency or Corporation, and you are not the Owner / Officer, we need an assignment of commissions signed by you. We must also have another Appointment Request Form completed by the Agency Owner / Officer; and copies of their license and the Agency's (if applicable).

**ANSWER THE FOLLOWING QUESTIONS**

1. Have you ever been convicted of a felony? \_\_\_\_\_\*
  2. Do you owe any unpaid balance to any Insurance Company, General Agent or Manager? \_\_\_\_\_\*
  3. Have you ever been involved in an investigation with any State Insurance Department? \_\_\_\_\_\*
  4. Has your license ever been suspended, cancelled or revoked by any State Insurance Department? \_\_\_\_\_\*
  5. Have you ever had your appointment terminated by another insurance company for any reason other than lack of production? \_\_\_\_\_\*
- \* If Yes to any questions 1 through 5, enclose complete details on a separate piece of paper, with your signature and date.
6. Are you currently licensed with Clarendon National Insurance Company? \_\_\_\_\_ If Yes, list your license #: \_\_\_\_\_

**COMMISSION ASSIGNMENT REQUEST**

**Only complete the following if you want HPA to pay your commissions to a Corp., Agency or another Agent.**

I \_\_\_\_\_  
\_\_\_\_\_ HPA Code # \_\_\_\_\_  
hereby assign to Assignee, \_\_\_\_\_  
all of my right, title, and interest in commissions and/or renewals to which I am now entitled or become entitled, under existing contracts and agreements, heretofore entered into by and between myself and Health Plan Administrators, Inc. I hereby authorize and empower Health Plan Administrators Inc., to pay assignee all commissions and renewals now due or which may accrue under said contracts, for a period of one year from this date and thereafter until such time as I terminate this assignment by written notice to Health Plan Administrators, Inc. I agree that such payments of commissions under my contract, the same as if payment was made directly to me. I hereby covenant and agree that I am the absolute and sole owner of said commissions, free from prior assignment or any encumbrance of any kind or character whatsoever, and that I have full right and lawful authority to sell and transfer the same as aforesaid.

Witness my hand this \_\_\_\_\_ Day of \_\_\_\_\_, Year \_\_\_\_\_, Agent's Signature: \_\_\_\_\_

**CAUTION:** The person assigning his or her commissions (assignor) will not recover the right to receive any further commissions during the one year period from the date of this assignment unless and until the person to whom such rights are assigned (assignee) releases, in writing, his or her rights to receive such commissions. Please be certain you understand this before signing the form. This instrument may be revoked, in writing, by the Assignor at any time after the one year period.

Address of Assignee: \_\_\_\_\_  
Tax I.D.# : \_\_\_\_\_ Assignee's HPA Code #: \_\_\_\_\_

**HPA STATEMENT OF UNDERSTANDING FORM**

HPA, Inc. (herein called HPA), agrees to pay commissions on the Plan s listed, based on the premiums due and paid to HPA, Inc., the plan administrator, in accordance with and subject to the conditions and covenants below.

**HEALTH-LINK STM 18% ~ FREEDOM STM 18%**

The term "premiums due and paid" shall mean monies, excluding any administrative fees or charges, due and paid for the Clarendon National Insurance Co. Freedom STM Plan to HPA after the effective date of this Agreement by each insured and for whom the producer is the Agent or broker of record. Commissions shall be payable only when Agent is (a) properly licensed to transact insurance business for the Clarendon National Insurance Co. and (b) is continuously recognized by the insurer as the agent or broker of record to receive said commissions. This Agreement may be terminated by either party with a 30 days written notice but only with respect to new cases. Such terminations will have no effect on the payment of commissions on business written prior to the effective date of termination as may otherwise be payable. No advertising material bearing HPA or the Insurance Company's name or describing or naming a product administered by HPA will be issued without prior written approval of HPA. The agent is an independent contractor, not an employee of HPA. The agent has no authority to act on behalf of the Clarendon National Insurance Co., bind insurance coverage, waive or alter any provision of the insurance application or the Policy under which a certificate of insurance is issued. Representation and opinion of the Agent are not binding on Clarendon National Insurance Co. By signing below I am giving HPA prior written express invitation and permission to transmit facsimile and email advertisements to me.

**READ CAREFULLY BEFORE SIGNING**

The above information is true and complete. I understand false statements on this form may be sufficient cause for termination. I have read the Agent Agreement and understand that if these guidelines are not followed, the result will be termination of the Agreement. I authorize Clarendon National Insurance Co. or it's duly authorized representative to contact any organization or individual who has knowledge of my past or present employment and financial status. Public Law requires that we advise you that a routine inquiry may be made during our initial or subsequent processing which will provide applicable information concerning character, general reputation, personal characteristics and mode of living. Upon written request additional information as to the nature and scope of the inquiry, if one is made, will be provided. A photocopy of this authorization shall be considered as effective and valid as the original.

Agent Signature	Date	Print Name	Title
GA Name: _____ Lawrence S. Brodsky	Address 865 E. Wilmette Rd., Unit I, Palatine, IL 60074	Telephone 847 991-8040	HPA Code # 050300000
MGA Name: _____	Address	Telephone	HPA Code #

**Please attach current copies of your insurance license. Mail this completed form to your MGA or to:  
HPA, INC. ~15436 N FLORIDA AVE, STE 105 ~ TAMPA, FL 33613  
or Fax completed form and license to 1-813-963-5570**

(CL AGT 5-04)