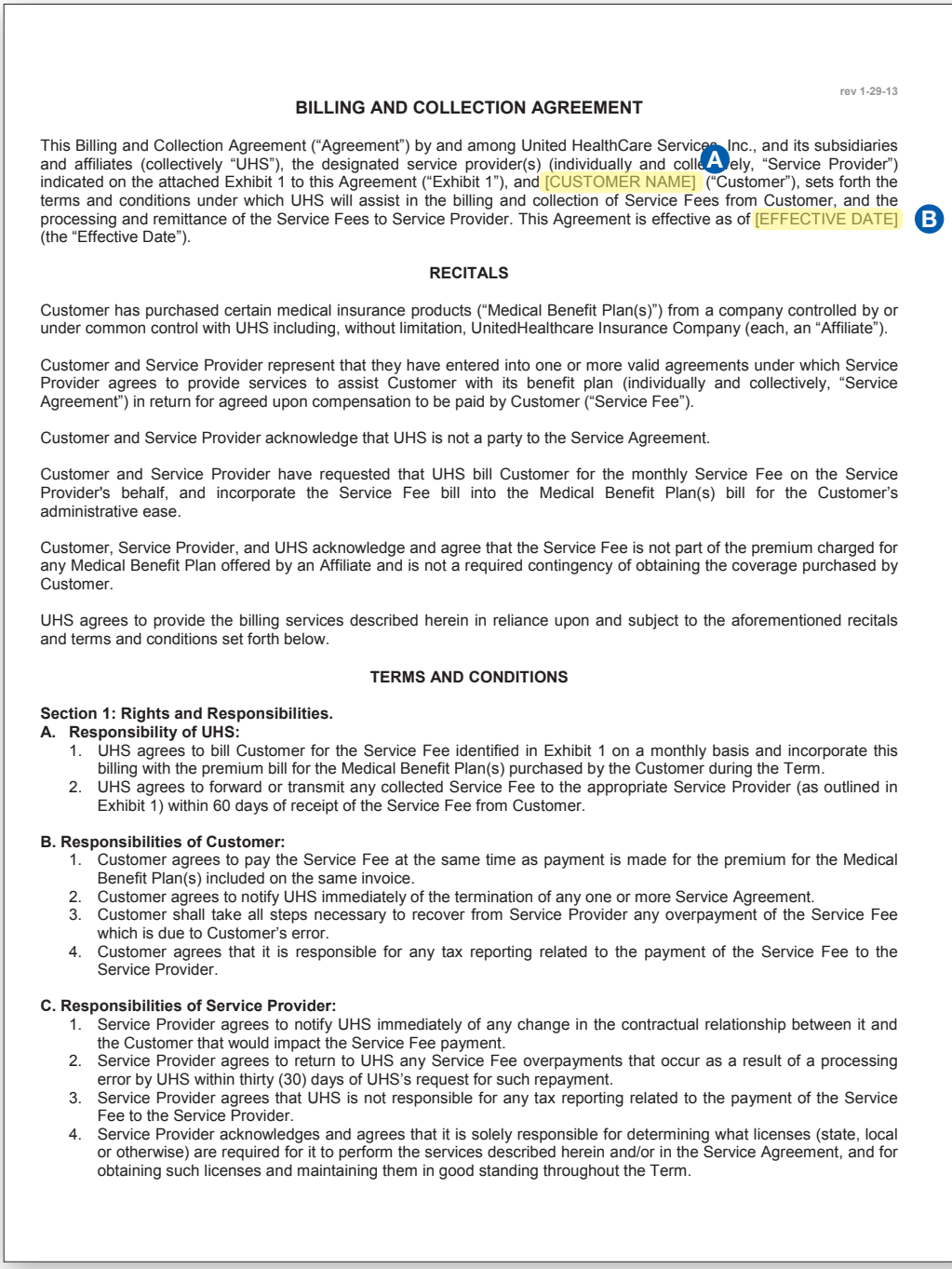
How to complete the Billing and Collection Agreement & Exhibit



rev 1-29-13

BILLING AND COLLECTION AGREEMENT

This Billing and Collection Agreement ("Agreement") by and among United HealthCare Services, Inc., and its subsidiaries and affiliates (collectively "UHS"), the designated service provider(s) (individually and collectively, "Service Provider") indicated on the attached Exhibit 1 to this Agreement ("Exhibit 1"), and [CUSTOMER NAME] ("Customer"), sets forth the terms and conditions under which UHS will assist in the billing and collection of Service Fees from Customer, and the processing and remittance of the Service Fees to Service Provider. This Agreement is effective as of [EFFECTIVE DATE] (the "Effective Date").

RECITALS

Customer has purchased certain medical insurance products ("Medical Benefit Plan(s)") from a company controlled by or under common control with UHS including, without limitation, UnitedHealthcare Insurance Company (each, an "Affiliate").

Customer and Service Provider represent that they have entered into one or more valid agreements under which Service Provider agrees to provide services to assist Customer with its benefit plan (individually and collectively, "Service Agreement") in return for agreed upon compensation to be paid by Customer ("Service Fee").

Customer and Service Provider acknowledge that UHS is not a party to the Service Agreement.

Customer and Service Provider have requested that UHS bill Customer for the monthly Service Fee on the Service Provider's behalf, and incorporate the Service Fee bill into the Medical Benefit Plan(s) bill for the Customer's administrative ease.

Customer, Service Provider, and UHS acknowledge and agree that the Service Fee is not part of the premium charged for any Medical Benefit Plan offered by an Affiliate and is not a required contingency of obtaining the coverage purchased by Customer.

UHS agrees to provide the billing services described herein in reliance upon and subject to the aforementioned recitals and terms and conditions set forth below.

TERMS AND CONDITIONS

Section 1: Rights and Responsibilities.

A. Responsibility of UHS:

1. UHS agrees to bill Customer for the Service Fee identified in Exhibit 1 on a monthly basis and incorporate this billing with the premium bill for the Medical Benefit Plan(s) purchased by the Customer during the Term.
2. UHS agrees to forward or transmit any collected Service Fee to the appropriate Service Provider (as outlined in Exhibit 1) within 60 days of receipt of the Service Fee from Customer.

B. Responsibilities of Customer:

1. Customer agrees to pay the Service Fee at the same time as payment is made for the premium for the Medical Benefit Plan(s) included on the same invoice.
2. Customer agrees to notify UHS immediately of the termination of any one or more Service Agreement.
3. Customer shall take all steps necessary to recover from Service Provider any overpayment of the Service Fee which is due to Customer's error.
4. Customer agrees that it is responsible for any tax reporting related to the payment of the Service Fee to the Service Provider.

C. Responsibilities of Service Provider:

1. Service Provider agrees to notify UHS immediately of any change in the contractual relationship between it and the Customer that would impact the Service Fee payment.
2. Service Provider agrees to return to UHS any Service Fee overpayments that occur as a result of a processing error by UHS within thirty (30) days of UHS's request for such repayment.
3. Service Provider agrees that UHS is not responsible for any tax reporting related to the payment of the Service Fee to the Service Provider.
4. Service Provider acknowledges and agrees that it is solely responsible for determining what licenses (state, local or otherwise) are required for it to perform the services described herein and/or in the Service Agreement, and for obtaining such licenses and maintaining them in good standing throughout the Term.

A This is the employer group name.

B This is the effective/live date of the Agreement. If this is a mid-year AOR change please review the time frame guidelines in the Internal FAQ. This will ensure you have the proper effective date on the Agreement.

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Section 2: Payments and Adjustments.

A. All parties agree to promptly notify the others upon becoming aware of an incorrect payment amount, and to promptly remit any amounts overpaid.
B. If the amount Customer pays to UHS for both Service Fee and premium related to the Medical Benefit Plan(s) purchased by Customer is less than the amount billed by UHS, the amount forwarded to the Service Provider will vary in direct proportion to the difference in the amount paid compared to the amount billed. This variation will apply regardless of the basis used for calculating the Service Fee, including a percent of premium, a set amount per enrolled employee, per month, or a set dollar amount per month.
C. UHS may recover overpayments from Service Provider by offsetting the overpayment against any other compensation due to Service Provider by UHS.
D. Service Fees will be subject to garnishments and any other legal attachments as required by a legal court order or similar action.
E. The Service Fee amount may be modified on a prospective basis only. UHS must be informed of the change in writing, including the date that the change will be implemented (which must be at least 30 days from the date of such notice to UHS). UHS will notify Customer and Service Provider in writing that it will implement the change on the date requested; provided, however, that UHS has the right to designate a date subsequent to the date requested if, in its reasonable judgment, UHS believes that such a delay is necessary.

Section 3: Amendments.

A. UHS may amend the terms and conditions of this Agreement, except for terms and conditions related to the amount of the Service Fee, at any time by notifying Customer and Service Provider of the change in writing at least 30 days prior to the effective date of the change.
B. Customer may request a change to the amount of the Service Fee subject to the requirements contained in Section 2(E) above.
C. All other amendments to the provisions of this Agreement, not addressed by 3(A) or 3(B) above, must be set forth in writing and signed by an authorized representative of each party to this Agreement.

Section 4: Term and Termination.

This Agreement is effective on the Effective Date and shall continue until terminated as set forth in this Section 4 (the "Term").

A. Customer may terminate this Agreement at any time, for any reason (or no reason), by providing written notice of such termination; provided, however, that if the termination does not specify a future effective date, Customer acknowledges and agrees that such termination will be effective the first of the month following UHS's receipt of such notice. Unless otherwise specifically so stated, notice that the Customer has elected to work with a different Service Provider shall be considered to be effective notice of the termination of this Agreement.
B. UHS and Service Provider may terminate this Agreement at any time, for any reason (or no reason), by providing written notice of such termination at least 60 or more days before the effective date of the termination.
C. UHS may terminate this Agreement immediately, upon written notice to Customer and Service Provider, if UHS is made aware that responsibilities and duties called for herein are no longer legally permissible.
D. This Agreement will terminate automatically and without any further action being required on the part of any party as of the effective date of the cancelation or termination of the last of the Medical Benefit Plan(s) purchased by Customer from an Affiliate then in existence.
E. In addition, this Agreement will terminate automatically and without any further action being required on the part of any party as of the effective date of a subsequently executed Billing and Collection Agreement by and between UHS, Customer and any service provider (whether the same Service Provider named in Exhibit 1 or not).
F. Notwithstanding the foregoing, the provisions of this Agreement which, by their nature, are intended to survive beyond the termination of this Agreement shall survive such termination, including, but not limited to, Sections 1(B), 1(C), 2(A), 2(C), 2(D), and 5.

Section 5: Additional Customer and Service Provider Acknowledgments and Approvals.

C A. Customer understands that UHS may compensate Service Provider for the sale, service and retention of Medical Benefit Plans and that the Medical Benefit Plan(s) purchased by Customer may, if eligible, be taken into account in the calculation of any bonus or override program offered by UHS to Service Provider. Eligibility for such bonus and/or override programs is determined by UHS based on a number of factors including, but not limited to, state-specific regulatory requirements.
B. By executing this Agreement below, Customer represents that either the payment of a bonus and/or override by UHS, as described in 5(A) above, does not create a conflict of interest or, to the extent of any apparent conflict, it is understood and hereby waived by Customer.

C This is the section of the Agreement that covers bonus eligibility. If the case is bonus eligible, it will automatically be included in the producer's bonus calculation when the completed Billing Agreement is received.

C. Customer and Service Provider acknowledge and agree that the Service Fee may be deposited by UHS in an interest bearing account with other money received, and that UHS may keep any interest earned from these accounts as consideration for UHS's services under this Agreement.
D. Service Provider acknowledges that UHS has no obligations to Service Provider to collect amounts owed to it by Customer other than those expressly set forth in this Agreement.
E. This Agreement represents the entire understanding and agreement between the parties with respect to the subject matter addressed herein and entirely and completely supersedes, voids and replaces all agreements, negotiations, understandings and representations (whether written or oral) in existence between the parties as of the Effective Date and relating to the same subject matter.
F. This Agreement may be executed in counterparts, each of which shall be deemed to be an original, but all of which, taken together, shall constitute one and the same Agreement. A signature by facsimile transmission or other electronic means which allows the identity of the signer to be reasonably confirmed shall be as good and binding as an original signature.

Signatures: Through the signature of their respective authorized representatives, the parties hereby agree to the terms and conditions of this Agreement.

For Customer: D

Signature – Authorized Representative of Customer

Printed Name

Title

Date

For Service Provider: E

Signature

Printed Name

SSN/TIN

Title

Date

For UHS: F

Signature – Authorized Representative

Printed Name

Title

Date

For Service Provider (if more than one): G

Signature

Printed Name

SSN/TIN

Title

Date

D The employer fills in the 4 lines below.

E This section must be completed by someone at the brokerage/agency. An individual authorized to bind the agency to the Agreement fills out this section and signs. This may be the service provider assigned to the case or a principal of the agency.

F The UnitedHealthcare Sales Rep or Health Plan leader must fill in the 4 lines below. This section must be complete prior to submission to the installation teams.

G This section is only used when there is more than one Service Provider and the service fees are split between them. An individual authorized to bind the agency to the Agreement fills out this section and signs. This may be the service provider assigned to the case or a principal of the agency.

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BILLING AND COLLECTION AGREEMENT

EXHIBIT 1

Customer Name: [_____]

Service Agreement Effective Date: [_____] H

Designation of Service Provider(s): Note: If more than two Service Providers are designated, please complete two versions of Exhibit 1 and provide relevant information for additional Service Providers on such additional Exhibits.

Designated Service Provider I **(Person or firm that will receive Service Fee):** [_____]	**Designated Service Provider** **(Person or firm that will receive Service Fee):** [_____] K
Service Provider Representative Responsible for Customer's Account: [_____] J	**Service Provider Representative Responsible for Customer's Account:** [_____]
Service Provider Address: [_____]	**Service Provider Address:** [_____]

PLEASE NOTE THAT THE INFORMATION CONTAINED IN THE BOX ABOVE MAY BE CHANGED PERIODICALLY BY UHS AS DIRECTED. ANY OTHER ALTERATIONS TO THE TOP HALF OF THIS FORM MUST BE INITIALED BY THE CUSTOMER TO DOCUMENT CONSENT TO THE CHANGE.

Please check only one of the following Service Fee payment methods and indicate the TOTAL rate to be paid.

[_] **Percentage of Medical Premium** [_____] % ***This option is not available for Ohio policies (use PEPM).***
(Please be advised that, unlike commissions, the Service Fee is not a component of premium.)

[_] **Per Employee Per Month (PEPM)** $ [_____] .00

IF MORE THAN ONE SERVICE PROVIDER IS LISTED ABOVE, PLEASE INDICATE **WITH SPECIFICITY** HOW THE TOTAL FEE SHOULD BE DIVIDED BETWEEN THE SERVICE PROVIDERS: _____

[_] Check here if the Designated Service Provider and Service Provider Representative named above are to be designated as the Agent of Record and Writing Agent, respectively, of all of the Customer's non-medical lines of coverage. Checking this box will replace the existing Agent of Record and Writing Agent for those lines of coverage. If more than one Service Provider is designated above, please indicate with specificity which, if any, non-medical lines of coverage should have changes to the currently designated Agent of Record:

_____

_____

Signature (Authorized Representative of Customer): _____

Name (Printed) [_____] **Title** [_____] **Phone** [_____]

For Internal Use Only (To be Completed By United HealthCare Services, Inc.)

UNET / BASICs Platform: *Please use "All" or list policies / state(s) covered by this specific agreement.

Payee / Producer ID:_____ Policy #: *_____

WA CRID:_____ Base / Situs State:_____

Customer #:_____ Agreement State*:_____

Oxford / Pulse Platform:

Payee Code:_____ Group #:_____

WA Code:_:_____ Base / Situs State:_____

FACETs Platform (RV/NHP):

Payee CRID:_____ Base / Situs State:_____

Arrangement ID*:_____ Agreement State:_____

West Coast / Nice Platform: (Requests for multiple payees and the amount to be paid to each should be listed out and attached)

Payee ID #_____ Payee Name_____

Writing Agent ID#_____ Writing Agent Name_____

All Group #s Covered by Agreement*: _____

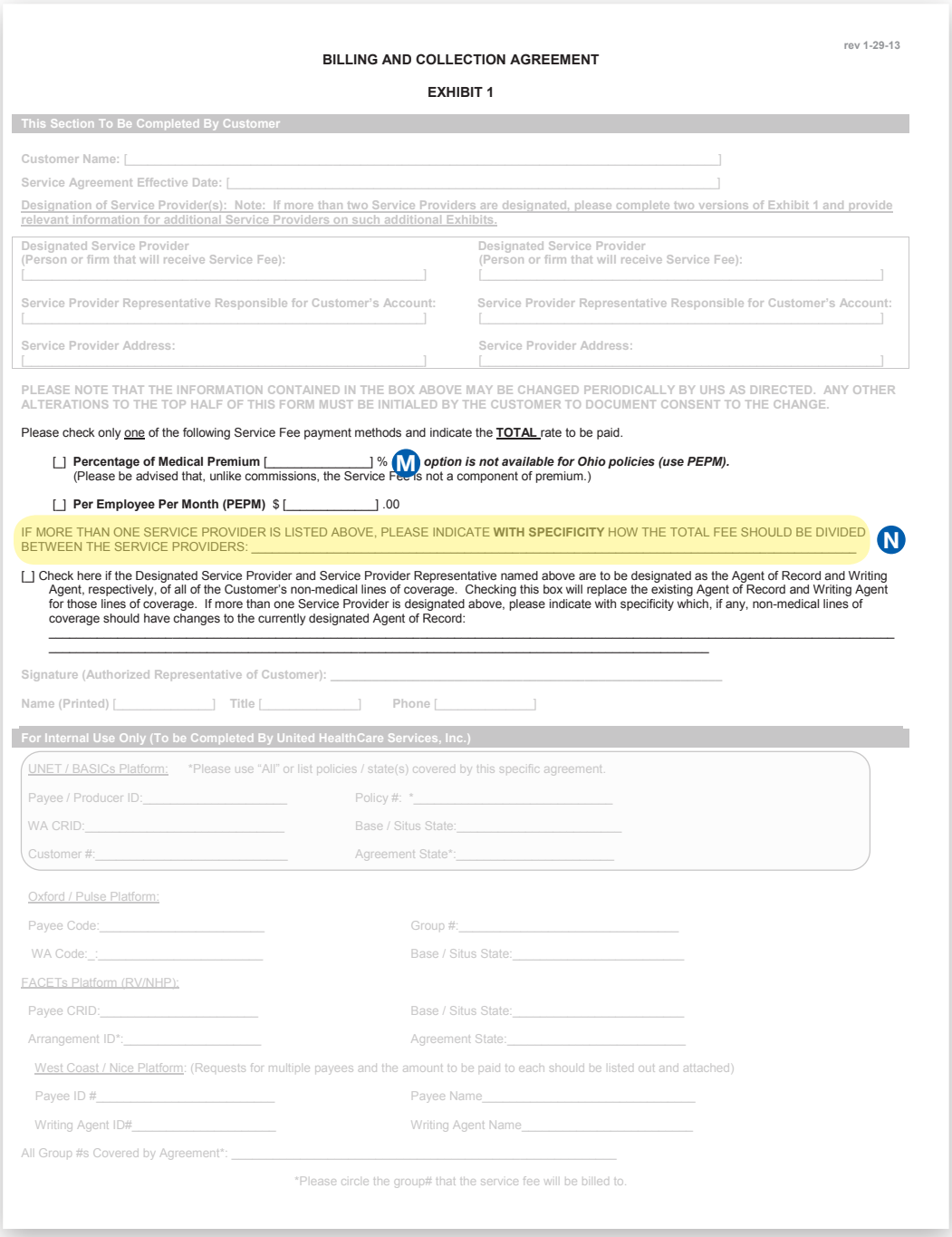
*Please circle the group# that the service fee will be billed to.

H The effective date must match the effective date on page one of the Billing Agreement and the effective date on the UAF.

I The Designated Service Provider is the payee, i.e. to whom we will be paying the Service Fee. More often than not, it's the agency. Sometimes they are the same. The Designated Service Provider must be licensed in the situs state and credentialed with UnitedHealthcare.

J This is the name of the person who will be servicing the account — for example they will receive a copy of the renewal and can call our service lines to resolve issues. The Service Provider Representative must be licensed in the situs state and credentialed with UnitedHealthcare.

K This line and the next two lines are only completed if there is more than one producer on the case and they are splitting the service fee.



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BILLING AND COLLECTION AGREEMENT

EXHIBIT 1

This Section To Be Completed By Customer

Customer Name: [_____]

Service Agreement Effective Date: [_____]

Designation of Service Provider(s): Note: If more than two Service Providers are designated, please complete two versions of Exhibit 1 and provide relevant information for additional Service Providers on such additional Exhibits.

Designated Service Provider (Person or firm that will receive Service Fee):	Designated Service Provider (Person or firm that will receive Service Fee):
[_____]	[_____]
Service Provider Representative Responsible for Customer's Account: [_____]	Service Provider Representative Responsible for Customer's Account: [_____]
Service Provider Address: [_____]	Service Provider Address: [_____]

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Please check only one of the following Service Fee payment methods and indicate the **TOTAL** rate to be paid.

L

[_] **Percentage of Medical Premium** [_____] % M ***option is not available for Ohio policies (use PEPM).***
(Please be advised that, unlike commissions, the Service Fee is not a component of premium.)

[_] **Per Employee Per Month (PEPM)** $ [_____] .00

IF MORE THAN ONE SERVICE PROVIDER IS LISTED ABOVE, PLEASE INDICATE **WITH SPECIFICITY** HOW THE TOTAL FEE SHOULD BE DIVIDED BETWEEN THE SERVICE PROVIDERS: _____ N

[_] Check here if the Designated Service Provider and Service Provider Representative named above are to be designated as the Agent of Record and Writing Agent, respectively, of all of the Customer's non-medical lines of coverage. Checking this box will replace the existing Agent of Record and Writing Agent for those lines of coverage. If more than one Service Provider is designated above, please indicate with specificity which, if any, non-medical lines of coverage should have changes to the currently designated Agent of Record:

_____

_____

Signature (Authorized Representative of Customer): _____

Name (Printed) [_____] Title [_____] Phone [_____]

For Internal Use Only (To be Completed By United HealthCare Services, Inc.)

UNET / BASICs Platform: *Please use "All" or list policies / state(s) covered by this specific agreement.

Payee / Producer ID:_____ Policy #: *_____

WA CRID:_____ Base / Situs State:_____

Customer #:_____ Agreement State*:_____

Oxford / Pulse Platform:

Payee Code:_____ Group #:_____

WA Code:_:_____ Base / Situs State:_____

FACETs Platform (RV/NHP):

Payee CRID:_____ Base / Situs State:_____

Arrangement ID*:_____ Agreement State:_____

West Coast / Nice Platform: (Requests for multiple payees and the amount to be paid to each should be listed out and attached)

Payee ID #_____ Payee Name_____

Writing Agent ID#_____ Writing Agent Name_____

All Group #s Covered by Agreement*: _____

*Please circle the group# that the service fee will be billed to.

L This section is where you note the payment method and amount and must match the UAF. If percent of medical premium, please note the difference in how service fees are calculated compared to commissions. If the client would like the producer to remain "whole" from the prior commission years, then you must use the converted Service Fee percentage - i.e. 5% commissions equals 5.26% Service Fee.

M If using a POP method you cannot go out more than 2 decimal points - i.e. 5.26%, 3.5%, or 3% are all allowable options.

N If two service providers are splitting the service fee you must indicate how we need to split the fee. This is an example of how we would like you to indicate the split: John Sample 25% of 5.26%; Mary Sample 75% of 5.26%.

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BILLING AND COLLECTION AGREEMENT

EXHIBIT 1

Customer Name: [_____]

Service Agreement Effective Date: [_____]

Designation of Service Provider(s): Note: If more than two Service Providers are designated, please complete two versions of Exhibit 1 and provide relevant information for additional Service Providers on such additional Exhibits.

Designated Service Provider (Person or firm that will receive Service Fee):	Designated Service Provider (Person or firm that will receive Service Fee):
[_____]	[_____]
Service Provider Representative Responsible for Customer's Account:	Service Provider Representative Responsible for Customer's Account:
[_____]	[_____]
Service Provider Address:	Service Provider Address:
[_____]	[_____]

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Please check only one of the following Service Fee payment methods and indicate the TOTAL rate to be paid.

[_] **Percentage of Medical Premium** [_____] % ***This option is not available for Ohio policies (use PEPM).***
(Please be advised that, unlike commissions, the Service Fee is not a component of premium.)

[_] **Per Employee Per Month (PEPM)** $ [_____] .00

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_____

_____

Signature (Authorized Representative of Customer): _____

Name (Printed) [_____] **Title** [_____] **Phone** [_____]

For Internal Use Only (To be Completed By United HealthCare Services, Inc.)

UNET / BASICs Platform: *Please use "All" or list policies / state(s) covered by this specific agreement.

Payee / Producer ID:_____ Policy #: *_____

WA CRID:_____ Base / Situs State:_____

Customer #:_____ Agreement State*:_____

Oxford / Pulse Platform:

Payee Code:_____ Group #:_____

WA Code:_:_____ Base / Situs State:_____

FACETs Platform (RV/NHP):

Payee CRID:_____ Base / Situs State:_____

Arrangement ID*:_____ Agreement State:_____

West Coast / Nice Platform: (Requests for multiple payees and the amount to be paid to each should be listed out and attached)

Payee ID #_____ Payee Name_____

Writing Agent ID#_____ Writing Agent Name_____

All Group #s Covered by Agreement*: _____

*Please circle the group# that the service fee will be billed to.

O The client must complete this section. The producer cannot sign on their behalf.

P If the Sales Representative has this information he/she should complete this section. If it is submitted with missing information the case will not be pended; producer operations will complete.