



February 3, 2020

Attestation

I hereby certify that I have read and understand the items on this form and that my answers are true and complete to the best of my knowledge. I have been advised that Healthfirst or any of its affiliated companies (Company), agents or subcontractors, may conduct investigations in connection with my request to represent the Company in the solicitation of Company products as described in the Healthfirst General Agent Agreement and/or Healthfirst Producer Agreement. I hereby consent to the Company requesting and obtaining all information as discussed in this application and for all such reports to be requested by and provided to the Company. I understand that a routine inquiry may be made as a requirement for state appointment and/or appointment with Company. If applicable, the Company may obtain reports from a consumer reporting agency, an investigation report or inquiries from a State Insurance Department. Any information that the Company obtains about me will be treated as confidential.

In signing this application I certify that I have not been convicted of any criminal felony involving dishonesty or breach of trust or been convicted of an offense under section 1033 of the Violent Crime and Law Enforcement Act of 1994. I further agree to immediately inform Company of any conviction of the types described in the preceding sentence. I agree to abide by the any applicable commissions disclosure requirements mandated by the State of New York. I understand and agree to follow the guidelines of Company's HIPAA Privacy Guidelines which are referenced in the Healthfirst General Agent Agreement and/or Healthfirst Producer Agreement.

I understand that if any of the information I provided is found to be incorrect or incomplete, it may be grounds for non-appointment or my immediate termination at the discretion of the Company.

My typed signature signifies my truthfulness and accuracy of the responses to the questions in this application as well as my agreement to the terms and conditions of the Healthfirst General Agent Agreement and/or Healthfirst Producer Agreement, as applicable.

Agent/Agency Name: \_\_\_\_\_

Agent/Agency NPN: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_