



You've Got the Talent - We've Got the Tools

# CONTRACTING WITH PINNACLE

## Welcome to Pinnacle Financial Services!

To get started, please fill out the forms included with this cover page and fax, or send using a secure email, back to us with these additional documents:

- Copy of your insurance license
- Copy of your E&O (if you carry it)
- Copy of a voided check for direct deposit
- Copy of proof of anti-money laundering training
- Copy of written explanation for any background issues (outlined on the *Background Information* page)
- Copy of CE training certificate (if required in your state)
- If applying as principal of a corporation, please provide a corporate license and voided check in addition to your individual license.
- If applying for Athene and are a corporation, please provide corporate resolution, or list of authorized signers
- ***Please be advised that some carriers charge resident and-or non-resident appointment fees. Contact **Pinnacle Financial Services** for details***

**Please fax to 267-386-8135 or send using the Secure Email on our website.**

If you have any questions, please call **1-800-772-6881** for assistance.

**We look forward to partnering with you!**

**REGISTRATION ON [WWW.PFSINSURANCE.COM](http://WWW.PFSINSURANCE.COM) IS REQUIRED TO PROCESS CONTRACTING**

**Attn: Jeff Palo**



## Contract Application

Agent Name: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Agency Name (if applicable): \_\_\_\_\_ Tax ID: \_\_\_\_\_ - \_\_\_\_\_  
 Personal Name or Principal: \_\_\_\_\_ Birth Date  
 Insurance License Number: \_\_\_\_\_ (mm/dd/yyyy): \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 NPN Number: \_\_\_\_\_  
 Male      Female  
 Agent Home Address: \_\_\_\_\_  
 City, State, ZIP: \_\_\_\_\_ County: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_  
 City, State, ZIP: \_\_\_\_\_ County: \_\_\_\_\_  
 UPS Street Address: \_\_\_\_\_  
 City, State, ZIP: \_\_\_\_\_ County: \_\_\_\_\_  
 Phone Res: \_\_\_\_\_ Business: \_\_\_\_\_  
 Fax: \_\_\_\_\_ Mobile: \_\_\_\_\_  
 Email Address: \_\_\_\_\_  
 Previous Address in the last 10 years: \_\_\_\_\_  
 City, State, ZIP: \_\_\_\_\_ County: \_\_\_\_\_

*By signing this form, I acknowledge that all information is true and correct to the best of my knowledge.*

*I agree to receive all carrier required emails, and Pinnacle Financial Services Compliance updates.*

*Additionally, by checking here, I agree to let Pinnacle Financial Services send me carriers, products, and lead opportunities.*

Preferred Method of Contact (can select multiple methods):      Email      Phone      Text

\_\_\_\_\_  
Initials

\_\_\_\_\_  
Date

**All Pages Must be Signed**

## Background Information

All Yes Answers Must Have an Explanation to be Processed

Is there any indebtedness to any insurance company? If yes, provide the name of the company, amount, and the repayment agreement:

Yes No

Have you ever been convicted of a felony or misdemeanor other than a traffic offense? If yes, explain and provide the date(s) of each:

Yes No

Have you had your driver's license revoked? If yes, explain and provide date(s):

Yes No

Are you in the process of, or have you ever, filed for bankruptcy? If yes, explain and answer the following questions:

Yes No

Have you ever filed bankruptcy, have been declared bankrupt or insolvent, or had your salary garnished?

Yes No

Have you, or any business of which you were presently are a principal, been involved in a bankruptcy action, or compromised liabilities with creditors?

Yes No

Have you ever filed a petition for bankruptcy or for protection from creditors?

Yes No

Has any insurance or securities brokerage firm, with whom you have been associated, ever filed a bankruptcy petition or been declared bankrupt (either during your association or within 5 years after termination of such association)?

Yes No

When was bankruptcy filed (mm/dd/yyyy)? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

What was the amount of your bankruptcy? \_\_\_\_\_

Please select which you filed: Chapter 7 Chapter 11 Chapter 13

Please provide the date you filed for bankruptcy (mm/dd/yyyy): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Please provide the date your bankruptcy was paid off (if applicable) (mm/dd/yyyy): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Are you now, or have you ever been, employed by, or associated with to any degree, directly or indirectly, a bank, savings and loan, or other financial institution?

Yes No

Are you now subject of any complaint, investigation, or proceeding which could result in a yes answer to any of the preceding questions?

Yes No

Initials

Date

**All Pages Must be Signed**

2 of 9 | Form #PFSCON0518



Have you ever been refused a bond or Errors and Omissions Insurance? If yes, please explain: Yes No

Have you ever had your insurance license suspended or revoked? If yes, please explain: Yes No

Have you ever had disciplinary action taken against you with any Department of Insurance? If yes, please explain: Yes No

Are you, or at this present time, or have you been within the past five years, involved in any civil litigation, judgments, liens, or foreclosures? If yes, please explain: Yes No

Have you ever been denied an appointment with any insurance company? If yes, please explain: Yes No

Have you ever been terminated for cause by any insurance carrier? If yes, please explain: Yes No

### Banking Information

Bank Routing Number (9 digits): \_\_\_\_\_

Account Number: \_\_\_\_\_

Branch Name or Location: \_\_\_\_\_

**BE SURE TO ATTACH A VOIDED CHECK**

### Other Information

Requesting Commission Advancing? Yes No

List a Beneficiary: \_\_\_\_\_ Relationship: \_\_\_\_\_

Resident Driver's License State: \_\_\_\_\_ Driver's License Number: \_\_\_\_\_

Have you taken out an AML (Anti-Money Laundering) course within the past two years? Yes No  
If yes, provide the date of the AML (Anti-Money Laundering):

Date (mm/yyyy): \_\_\_\_ / \_\_\_\_ Course Name: \_\_\_\_\_

Where were you born? (City,State) \_\_\_\_\_

**LONG TERM CARE PARTNERSHIP CERTIFICATION: PLEASE ATTACH CERTIFICATE OR CE UPDATE**

*I confirm that all information is true and correct, and I have given Pinnacle Financial Services my permission to enter the information on my behalf.*

\_\_\_\_\_  
Initials

\_\_\_\_\_  
Date



# Additional Information (SelectHealth)

IF NOT SELECTING SELECTHEALTH AS A CARRIER, PLEASE DISREGARD THIS PAGE

**Professional Information**

Nevada Accident and Health Insurance License Number: \_\_\_\_\_

Issue Date (mm/dd/yyyy): \_\_\_\_ / \_\_\_\_ / \_\_\_\_    Expiration Date (mm/dd/yyyy): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Please list the names of the carriers with which you are currently appointed, or applying for appointment:

Have you ever been cited, fined, suspended, revoked, or refused a license by any state?      Yes      No

If yes, provide the state, month, and year:    State: \_\_\_\_\_ Date (mm/yyyy): \_\_\_\_ / \_\_\_\_\_

**Professional References**

List any professional associations to which you belong:

Name of Organization: \_\_\_\_\_

Member Since (mm/dd/yyyy): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name of Organization: \_\_\_\_\_

Member Since (mm/dd/yyyy): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

List two professional references that can attest to your honesty, professionalism, and ethical standards of practice:

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Disciplinary Actions**

Have you ever been excluded from participating in a government healthcare program such as Medicaid or Medicare?      Yes      No

If yes, please provide complete background and detail of circumstances, paying particular attention to activities affecting interstate commerce, (if needed, you may attach another page):

*By signing this form, I acknowledge that all information is true and correct to the best of my knowledge.*

\_\_\_\_\_  
Initials      Date



## Letter of Explanation

Date of Action (mm/dd/yyyy): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Action: \_\_\_\_\_

Reason: \_\_\_\_\_

Explanation:

Date of Action (mm/dd/yyyy): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Action: \_\_\_\_\_

Reason: \_\_\_\_\_

Explanation:

Date of Action (mm/dd/yyyy): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Action: \_\_\_\_\_

Reason: \_\_\_\_\_

Explanation:

USE ADDITIONAL PAPER IF NECESSARY

### Licenses

AML Provider:    Limra    None    Other    Date Completed (mm/dd/yyyy): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

*If other, please provide certificate of completion*

Are you a Registered Rep with FINRA?    Yes    No

*If yes, Broker/Dealer Name:* \_\_\_\_\_ *CRD#:* \_\_\_\_\_



## Agent Referral Information

Agent Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Agent Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Agent Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Agent Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Agent Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Agent Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Agent Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Agent Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Agent Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Agent Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

## You Can Earn Extra Money

**CALL YOUR SALES DIRECTOR FOR MORE DETAILS ON OUR REFERRAL PROGRAM!**

65 W Street Rd, Suite A-101 | Warminster, PA 18974 | 800-772-6881 | 267-386-8136 | [www.pfsinsurance.com](http://www.pfsinsurance.com)



## Replace this page with a copy of your E&O Insurance Certificate of Coverage

**IMPORTANT:** E&O Certificate must list your full name as the insured.

Please use the following examples as reference:

### **CORRECT:**

Name of Insurance Agency

**Full Agent Name**

Address Line 1

Address Line 2

City, State, ZIP

### **INCORRECT:**

Name of Insurance Agency

Address Line 1

Address Line 2

City, State, ZIP

If an individual's name is not listed correctly, please provide a letter  
from the E&O Carrier listing agents covered under agency policy.





## Signature

GENERAL AGENT: Pinnacle Financial Services

I, \_\_\_\_\_, hereby authorize Pinnacle Financial Services to affix or append a facsimile of my signature, as set forth below, to all required signature fields on all Insurance Carrier documents through the software or through any other means, including without limitation, by e-mail or orally. For which I have authorized Pinnacle Financial Services to submit all such forms and agreements on my behalf, for the purposes of being Contracted to sell products of Carriers through Pinnacle Financial Services. I hereby release, indemnify and hold harmless Pinnacle Financial Services against any and all claims, demands, losses, damages, and causes of action, including: expenses, costs and reasonable attorneys' fees, which they may sustain or incur as a result of carrying out the authority granted hereunder.

I affirm that the information I have submitted through the interview process to Pinnacle Financial Services 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 claims, demands, losses, damages, and causes of action, including: expenses, costs and reasonable attorneys' fees, which such third party may incur as a result of its reliance and acceptance on any form or agreement of a facsimile of my signature.

By signing this form, I acknowledge that all information is true and correct to the best of my knowledge.

**Please read, sign, and fax back to **267-386-8135****  
**Additionally, please sign in the center of the box below:**

**Example:**

A handwritten signature in black ink that reads "John Doe". The signature is written in a cursive, flowing style. It is contained within a rectangular box.



Check the box next to the Carrier names that you would like to select. For non-resident state requests, please write in state next to the carrier. Please be advised that some carriers charge resident and-or non-resident appointment fees. If you are requesting non-resident appointment, please indicate what states in the block provided.

Carriers	✓	Non-Res States	Carriers	✓	Non-Res States
Aetna Medicare Advantage/Coventry			Humana		
Aetna Medicare Supplement (ACI/CLI)			John Hancock		
AGLA- Life with Living Benefits			Liberty Bankers- Med Supp		
American Equity			Lincoln Financial		
American General- Life Brokerage Annuity			LUMICO MS		
Americo			Medico Group		
Americo- Legacy			MetLife		
Anthem BCBS/Empire/ Amerigroup/Caremore			MOO MA		
Assurity Legacy			Mutual of Omaha Insurance Company (Omaha Insurance, United of Omaha Life Ins., United Word Life Ins.)		
Athene Annuity & Life Assurance Company			National Guardian Life		
Athene, IA- Annuity			National Guardian Life- Med Supp		
Baltimore Life			National Western		
Banker's Fidelity Life/ Assurance Company			Nationwide		
Banner Life			North American Company (NACOLAH)- Life & Annuity		
Cigna- Final Expense/Med Sup (Arlic/Loyal American/CHLIC)			Protective Life		
Cigna- HealthSpring (Bravo Health)			Royal Neighbors of America		
Columbian Mutual Life Insurance Company			SelectHealth		
Combined Insurance Company of America			Sentinel Security Life Insurance Company		
Equitrust			The Standard		
F&G			Thrivent- Med Supp		
F&G (Legacy)			Transamerica New York		
Freedom/Optimum			Transamerica Premier		
Fresenius			United Home Life		
Genworth LTC			United Security Assurance		
Gerber Life- Medicare Supplement			UnitedHealthcare		
Gerber Life Insurance Company			USIC MS		
Global Atlantic			Washington National		
Great American			WellCare		
Great Western- GI Life			William Penn		
Guarantee Trust Life			Other:		

Initials

Date

**All Pages Must be Signed**

9 of 9 | Form #PFSCON0518