AGENT APPOINTMENT APPLICATION

EquiTrust Life Insurance Company®
7100 Westown Parkway, Suite 200
West Des Moines, Iowa 50266-2521
(866) 598-3692 Fax: (515) 226-5102
www.EquiTrust.com
Mailing Address: PO Box 14500
Des Moines, Iowa 50306-3500

If applying for both principal agent and agency, and the answers for the respective appointments differ, please use separate applications.

Name (as it appears on your license)	Date of Birth		Sex ☐ Male ☐ Female
Business Name	Email		
Business Address	City	State	Zip
Business Phone	Fax		
Social Security Number	Taxpayer Identification Number		
CRD Number (if securities licensed)	Broker/Dealer Name		

Do you currently have a debit balance with any insurance company? ☐ Yes ☐ No
If "Yes" give the company name and balance _____ Balance: $

a. Have you ever had your insurance license suspended or revoked?	☐ Yes ☐ No
b. Have you ever had a complaint filed against you with an insurance department?	☐ Yes ☐ No
c. Has any claim ever been made against you, your surety company, or errors and omissions insurer arising out of insurance sales, or have you been refused surety bonding?	☐ Yes ☐ No
d. Have you ever been convicted of a felony?	☐ Yes ☐ No
e. Have you ever been convicted of a misdemeanor, including but not limited to crimes involving dishonesty, breach of trust, or a violation of federal law?	☐ Yes ☐ No
f. Have you ever been party to any litigation?	☐ Yes ☐ No
g. Are there any unsatisfied judgements outstanding against you?	☐ Yes ☐ No

If you answer yes to any of the questions above, please attach the applicable items listed below. Failure to do so will result in your request for appointment being declined.
a) A written statement explaining the circumstances of each incident
b) A certified copy of the charging document
c) A certified copy of the official document which demonstrates the resolution of the charges or any final judgement.

EquiTrust Life Insurance Company

AGENT'S DECLARATION AND AUTHORIZATION

1. I hereby certify that all my answers to the above questions are true. I understand that this application will form a part of my Agent's Contact with EquiTrust Life Insurance Company (the Company) and the information is, to the best of my knowledge, an accurate statement of fact. I further understand that if any material information given in this application is found to be incorrect or incomplete, it will be grounds for rejecting the appointment application or for contract termination for cause at the sole discretion of the Company.
2. *Certification* – under penalty of perjury, I certify that:
   a. The Social Security Number or Taxpayer Identification Number shown on this form is correct (or I am waiting for a number to be issued to me).
   b. I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.
3. I acknowledge that I have reviewed both the Business Guidelines and Annuity Suitability Agent User Guide (ET-3107), and understand that as an appointed agent of EquiTrust, it is my responsibility to abide by EquiTrust's policies and procedures defined in both documents, including all applicable statutes and regulations. I agree to review the Business Guidelines and Annuity Suitability Agent User Guide at least once per year. I understand it is my responsibility to seek clarification from EquiTrust's Compliance Department if I have any questions about either document.

Applicant Signature	Date

AUTHORIZATION FOR DISCLOSURE OF PERSONAL INFORMATION AND CONSENT TO INVESTIGATIVE CONSUMER REPORT

I have applied for appointment with EquiTrust Life Insurance Company (the "Company"). To enable the Company to properly verify and evaluate my qualifications, I understand that the Company need access to certain personal information about me.

I hereby authorize any employer or former employer, any school, any police department or other law enforcement organization, any financial institution, any consumer reporting agency, or any other person or organization having information about me to furnish to any insurance company affiliated with EquiTrust Life Insurance Company with any and all information that such person or organization has in its possession, including credit information.

I further acknowledge that one or more investigative consumer reports may be made in which information about my character, general reputation, personal characteristics, and/or mode of living is obtained through personal interviews with individuals such as neighbors, friends, or associates of mine. I hereby acknowledge and consent to the Company obtaining and utilizing such reports in its decision to contract with me. I understand that I have the right to make a written request to the Company within a reasonable period of time for a complete and accurate disclosure of additional information concerning the nature and scope of the investigation, and that I may obtain a summary of consumer rights upon request.

I certify that I have received from the Company all disclosures required by the Fair Credit Reporting Act.

A photocopy of this authorization is as valid as an original. I specifically waive any written notice from any present or former employer who may provide information based on this authorization. I understand this authorization will become a part of a written appointment application.

I acknowledge and agree that should I become associated with the Company in the position of agent, this Authorization shall remain valid and in effect and will allow the Company to obtain such reports as the Company deem necessary on an ongoing basis without any additional notice or consent during the term of such association.

DEBIT CHECK AGENT/AGENCY AUTHORIZATION

Vector One Operations, LLC dba Vector One manages the secured web portal interactive computer service provided by Debit-Check.com, LLC. This Debit-Check Agent/Agency Authorization is used by Debit-Check subscribers who desire to be granted authorization from you for the submission and/or receipt of your personal information to the Debit-Check service as necessary to conduct a commission related debit balance screening. EquiTrust Life Insurance Company is a Debit-Check subscriber. Accordingly, as part of the contracting and appointment process or determination of eligibility for advancement of commissions, EquiTrust may conduct a commission related debit balance screening via Debit-Check in order to determine your eligibility and may continue to conduct periodic commission related debit balance screenings as determined in EquiTrust's sole discretion following the engagement of any employment, appointment, contract, tenure or other relationship with EquiTrust.

EquiTrust is hereby authorized to obtain and conduct a commission related debit balance screening through Vector One's Debit-Check secured web portal to determine if another Debit-Check subscriber has posted that I have an outstanding commission related debit balance. I understand that EquiTrust may consider the results of the commission related debit balance screening to determine my eligibility to be contracted and appointed or determine my eligibility for advancement of commissions as an insurance principal and may continue to conduct periodic commission related debit balance screenings as determined in EquiTrust's sole discretion following the engagement of any employment, appointment, contract, tenure, or other relationship with EquiTrust. I understand and acknowledge that EquiTrust may obtain commission related debit balance information through Debit-Check as state law allows. I understand that My Information, including the information provided above ("My Information"), may be used for the purpose of obtaining and conducting a commission related debit balance screening. I authorize and direct Vector One to receive and process My Information as necessary to intentionally disclose and furnish the results of my commission related debt verification screening, whether directly or indirectly, to EquiTrust. I further understand that in the event of termination or expiration of my employment, appointment, contract, tenure, or other relationship with EquiTrust, whether voluntary or involuntary, if a commission related debit balance is owed to EquiTrust. EquiTrust may post My Information to the Debit-Check service which may be accessed by Debit-Check subscribers until such time the debit balance is satisfied or otherwise removed. I authorize and direct Vector One to receive and process My Information and intentionally disclose to any Debit-Check subscriber who submits an inquiry utilizing my information the results of my commission related debit balance screening, which will contain My Information, to the extent a debit balance is owed.

FAIR CREDIT REPORTING ACT NOTICE

I acknowledge that EquiTrust Life Insurance Company (“EquiTrust”) may now, or at any time while a business relationship exists, request consumer reports and/or investigative consumer reports through Business Information Group Inc. (“BIG”) that may include information as to my character, general reputation, personal characteristics, or mode of living, work habits, performance or experience, along with reasons for termination of past employment/professional licenses or credentials; financial/credit history; or criminal or civil record history for the purpose of obtaining information which may be material to my qualifications for appointment.

If an adverse action is taken based in whole or in part on information contained in the report, EquiTrust will notify you of the adverse action and provide contact information with respect to the consumer reporting agency as required by the Fair Credit Reporting Act.

With respect to a consumer report, you have the right to request, in writing, within a reasonable time, that BIG make a complete and accurate disclosure of the nature and scope of the information requested. Communications with BIG should be directed to Business Information Group, Inc., P.O. Box 541, Southampton, PA 18966, Telephone (800) 260-1680, www.bigreport.com.

By signing below, I hereby authorize all entities having information about me as described above to release such information to BIG. I acknowledge that this is a continuing authorization during the term of my business relationship.

FOR CALIFORNIA, MINNESOTA, AND OKLAHOMA APPLICANTS ONLY

You have the right to request a copy of any consumer report we may order. If you wish to receive a copy, you will indicate your desire to do so by emailing a request to Agent.Administration@EquiTrust.com.

California Applicants: If you indicate that you would like to receive a copy of the consumer report, the report will be provided to you within three (3) business days after we receive the requested reports. Under section 1786.22 of the California Civil Code, the investigative consumer reporting agency shall supply the requested information during normal business hours and on reasonable notice. You may also obtain a copy of this information by: (1) appearing in person, furnishing proper identification, and paying the costs of duplication services; (2) a written request sent certified mail, with proper identification; or (3) telephone, upon a written request and with proper identification. The agency is required to have personnel available to explain the information furnished to you and the agency must provide a written explanation to you of any coded information appearing in your file. If you appear in person, a person of your choice may accompany you, provided that this person furnishes proper identification.

"Proper Identification" includes documents such as a valid driver's license, social security account number, military identification card, and credit cards. Only if you cannot identify yourself with such information may the ICRA require additional information concerning your employment and personal or family history in order to verify your identity. The ICRA will provide trained personnel to explain any information furnished to you and will provide a written explanation of any coded information contained in files maintained on you. This written explanation will be provided whenever a file is provided to you for visual inspection.

You may be accompanied by one other person of your choosing, who must furnish reasonable identification. An ICRA may require you to furnish a written statement granting permission to the ICRA to discuss your file in such person's presence.

By signing below, I acknowledge that I have read the above.

Date: _____ Applicant Signature: _____

Print Full Name: _____

For Massachusetts appointments only. If not requesting appointment in Massachusetts, please disregard this page.

Dear Massachusetts Producer

All persons that own, license, store or maintain personal information about a resident of Massachusetts are required to meet certain standards for protecting paper and electronic records.

Personal information may include a resident's name in combination with Social Security, drivers license, state-issued identification card, financial account number or credit card numbers.

Please review Massachusetts 201 CMR 17.00 Compliance Checklist and the corresponding comprehensive security program components, both available on the EquiTrust agent website, for specific requirements regarding your responsibility for maintaining these records. Go to EquiTrust.com>Fixed Annuities>Buzz item titled "New Massachusetts Regulation." Also, please sign the acknowledgment below and fax to EquiTrust so that we may continue your appointment.

Thank you for your attention to this important matter.

Sincerely,

Emily Kresowik
Compliance
Phone: 877-249-3694

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Please sign & fax a copy of this to EquiTrust Life Insurance Company at (515)226-5102

I hereby certify by signing below that I have reviewed Massachusetts 201 CMR 17.00 Compliance Checklist and the corresponding comprehensive security program components. I further certify that I am in compliance with the requirements of MA 201 CMR 17.00. I understand that it is my responsibility to ensure that I continue to meet the requirements of MA 201 CMR 17.00 and agree to take necessary steps to ensure such continued compliance. If acting in a management capacity, this certification extends to my organization.

By: _____

Name (print): _____

Title: _____

Date: _____

AGENT LICENSE AGREEMENT

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AN AGREEMENT BETWEEN EQUITRUST LIFE INSURANCE COMPANY

AND _____ (Licensee)

I _____ _____ request that the company make application with the Department of Insurance in my resident state for the issuance of a life insurance agent's license authorizing me to solicit applications on behalf of EquiTrust Life Insurance Company.
I hereby agree that your consent to the issuance for such license is subject to, and I agree hereby to be bound by, each and all of the following conditions:

1. That I shall be an agent assigned to and under the jurisdiction of the agent listed below.
2. That the Company has no obligation to me for commissions, expense allowances or any form of compensation whatsoever in connection with the services performed and expenses incurred by me in the solicitation of applications for insurance issued by the Company, it being expressly understood that I am under direct contract with my agent, who has agreed to compensate me for such services; and
3. That I have no contractual relationship with the Company and that I am not, and I shall refrain from holding myself out as employee, partner, joint venturer or associate of the Company; and
4. That I shall comply with the rules, regulations and rate books of the Company, the laws of my state or states in which I am licensed, and the regulations of the Department of Insurance relating to my activities in the solicitation of insurance; and
5. That I shall ensure that the Company and my sponsoring agent have my current contact information, including but not limited to, email, mailing address and phone number; and
6. That I shall not alter, modify, waive or change any of the terms, rates or conditions of an advertisements, receipts, policies or contracts of the Company, in any respect; and
7. That I shall promptly remit to my agent or the Company any and all monies or securities received by me on behalf of the Company, full or partial payment of first-year or renewal premiums, or any other item whatsoever; and
8. That I shall not obligate the Company nor incur expense in its behalf in any manner whatsoever; and
9. That the Company may, without liability to me whatsoever, upon request of my agent or upon its own initiative, cancel my license at any time.
10. I acknowledge receipt of the Company's privacy policy regarding use of policyholder information and I agree to comply with the terms of such policy, as applicable.

FOR HOME OFFICE USE ONLY
Date of effective agreement (month/day/year) _____ ____, 20_____ .

This applicant is recommended for appointment as an agent assigned to my jurisdiction, subject to the terms of my agent's contract with the Company and this agreement.	
Agent Signature (Licensee)	
Individual /Agency receiving commissions	Signature of Individual/ Agency principal
The Company approves the above agreement subject to all provision herein.	
Authorized Home Office Signature	

AGENT CONTRACT TRANSMITTAL FORM

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Des Moines, Iowa 50306-3500

This form should be completed for:

- Any new agents being contracted by you, or
- Any changes you are requesting to an existing agent's commission level, or
- Agents requesting a transfer to a new Marketing Organization

This form must be included with each new agent contract or to request a change of existing level.

☐ **NEW AGENT/PRODUCER** ☐ **TRANSFER OR CHANGE IN CONTRACT LEVEL**

Full Name of Agent being contracted	
Business Name (if different than Producer's Name)	
Agent Contract Level (e.g. MGA, GA, A10)	
Agency Contract Level (e.g. MGA, GA, A10)	
Reports to	Agent Number

Agent's Signature (**Required**)	Date (**Required**)

Marketing Organization Name (**Please Print**)	
Authorized Signature (**Required**)	Date (**Required**)

Mail to:
EquiTrust
Attn: Agent Administration
PO Box 14500
Des Moines, IA 50306-3500

Can also be sent via fax or email to:
515-226-5102 or Agent.Administration@EquiTrust.com

FOR INTERNAL HOME OFFICE USE ONLY
_____
_____
_____

HIPAA BUSINESS ASSOCIATE ADDENDUM

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This Business Associate Addendum ("Addendum") by and between **EquiTrust Life Insurance Company** ("EquiTrust" or "Insurer") and ("Agent" or "Business Associate"), is effective as of the effective date of that certain Agent/Agency Contract (the "Agent/Agency Contract") between EquiTrust and Business Associate. EquiTrust and Business Associate may be referred to herein individually as a "party" or collectively as the "parties." For purposes of this Addendum, capitalized terms used but not otherwise defined in this Addendum shall have the meaning as set forth in Section D.1 herein below.

WHEREAS, EquiTrust offers long-term care insurance riders (the "Covered Products"), which are health plans covered under the Health Insurance Portability and Accountability Act of 1996; and

WHEREAS, Insurer and Agent have entered into the Agent/Agency Contract under which Agent is authorized to market, sell and service the Covered Products and other products issued by the Insurer; and

WHEREAS, for purposes of compliance with the Health Insurance Portability and Accountability Act of 1996 and the Health Information Technology for Economic and Clinical Health Act of 2009 and regulations promulgated thereunder (collectively referred to herein as "HIPAA"), EquiTrust has designated itself as a Hybrid Entity pursuant to 45 C.F.R. § 164.103 and 45 C.F.R. § 164.105 and has identified certain units and departments within EquiTrust that perform Covered Functions as Health Care Components that are regulated by HIPAA; and

WHEREAS, with respect to Covered Products, Business Associate performs services under the Agent/Agency Contract on behalf of Insurer's Health Care Components ("Services"), which Services involve the use and/or disclosure of Protected Health Information; and

WHEREAS, the parties desire to enter into this Addendum in order to comply with the provisions of HIPAA that are applicable to Business Associate, as well as any amendments or additions thereto;

NOW, THEREFORE, in consideration of these premises and the mutual promises and undertakings herein contained, the parties agree as follows:

A. Privacy and Security of Protected Health Information

1. Permitted Uses and Disclosures

Business Associate is permitted or required to use or disclose Protected Health Information it creates or receives for or from Insurer only as follows:

a) Functions and Activities on Insurer's Behalf. Business Associate is permitted to use and disclose Protected Health Information it creates or receives for or from Insurer solely for carrying out its obligations under the Agent/Agency Contract.

b) Business Associate's Operations. Business Associate may use Protected Health Information it creates or receives for or from Insurer as necessary for Business Associate's proper management and administration or to carry out Business Associate's legal responsibilities. Business Associate may disclose the Protected Health Information as necessary for Business Associate's proper management and administration or to carry out Business Associate's legal responsibilities only if:

(i) The disclosure is required by law; or

(ii) Business Associate obtains reasonable assurance, evidenced by written contract, from any person or organization to which Business Associate will disclose the Protected Health Information that the person or organization will:

a. Hold the Protected Health Information in confidence and use or further disclose it only for the purpose for which Business Associate disclosed it to the person or organization or as required by law; and

b. Notify Business Associate (who will in turn promptly notify Insurer) of any instance of which the person or organization becomes aware in which the confidentiality of such Protected Health Information was breached.

2. Notice of Privacy Practices. Insurer shall notify Business Associate of limitation(s) in its notice of privacy practices, to the extent such limitation affects Business Associate's permitted uses or disclosures of Protected Health Information.

3. Prohibition on Unauthorized Use or Disclosure

Business Associate will neither use nor disclose Protected Health Information it creates or receives for or from Insurer or from another Business Associate of Insurer, except as permitted or required by this Addendum or as required by law or as otherwise permitted in writing by Insurer. Business Associate shall not use or disclose Protected Health Information in any manner that violates HIPAA or any other applicable federal or state laws and regulations relating to the privacy and security of Protected Health Information.

4. Information Safeguards

(a) Administrative, Technical, and Physical Safeguards. Business Associate will develop, implement, maintain and use appropriate administrative, technical and physical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of, and that prevent non-permitted or violating use or disclosure of, Protected Health Information that it creates, receives, or transmits on behalf of Insurer. Business Associate will document and keep these safeguards current.

(b) Technology to Secure Protected Health Information. With respect to all electronic Protected Health Information that Business Associate transmits electronically or stores on portable electronic devices, Business Associate will secure the Protected Health Information by a technology standard that renders the Protected Health Information unusable, unreadable or indecipherable to unauthorized individuals. Business Associate shall comply with the applicable standards of 45 C.F.R. §§ 164.306, 164.308, 164.310, 164.312, 164.314, and 164.316 with respect to electronic Protected Health Information.

5. Sub-Contractors and Agents

Business Associate will require any of its subcontractors and agents, including but not limited to Sub-Agents as defined in the Agent/Agency Contract, to which Business Associate is permitted by this Addendum or in writing by Insurer to disclose any of the Protected Health Information Business Associate creates or receives for or from Insurer, to provide reasonable assurance, evidenced by written contract, that subcontractor or agent will comply with substantially similar privacy and security obligations as Business Associate with respect to the Protected Health Information.

6. Minimum Necessary

Business Associate will, in its performance of the functions, activities, services, and operations specified in Section A.1(a) above, make reasonable efforts to use, to disclose, and to request only the minimum amount of Protected Health Information reasonably necessary to accomplish the intended purpose of the use, disclosure or request, except that Business Associate will not be obligated to comply with this minimum necessary limitation with respect to:

a) Disclosure to or request by a health care provider for treatment;

b) Use with or disclosure to an individual who is the subject of the Protected Health Information, or that individual's personal representative;

c) Use or disclosure made pursuant to a written authorization that is signed by an individual who is the subject of the Protected Health Information to be used or disclosed, or by that individual's personal representative who has the authority to act on behalf of that individual; or

d) Use or disclosure that is required by law.

B. Protected Health Information Access, Amendment and Disclosure Accounting.

1. Access

Upon Insurer's request, Business Associate will promptly make available to Insurer or, at Insurer's direction, to the individual (or the individual's personal representative) for inspection and obtaining copies any Protected Health Information about the individual (in a format, electronic or otherwise, designated by Insurer) that Business Associate created or received for or from Insurer and that is in Business Associate's custody or control.

2. Amendment

Business Associate will, upon receipt of notice from Insurer, promptly amend or permit Insurer access to amend any portion of the Protected Health Information which Business Associate created, received or maintains on behalf of Insurer.

3. Disclosure Accounting

So that Insurer may meet its disclosure accounting obligations:

a) Disclosure Tracking

Business Associate will record for each disclosure of Protected Health Information not excepted from disclosure accounting under Section B.3(b) below, (i) the disclosure date, (ii) the name and (if known) address of the person or entity to whom Business Associate made the disclosure, (iii) a brief description of the Protected Health Information disclosed, and (iv) a brief statement of the purpose of the disclosure (items i-iv, collectively, the "disclosure information"). For repetitive disclosures Business Associate makes to the same person or entity for a single purpose, Business Associate may record (i) the disclosure information for the first of these repetitive disclosures, (ii) the frequency, periodicity or number of these repetitive disclosures, and (iii) the date of the last of these repetitive disclosures. Business Associate will make this disclosure information available to Insurer promptly upon Insurer's request or, as directed by Insurer, to the individual (or the individual's personal representative).

b) Exceptions from Disclosure Tracking

Business Associate need not record disclosure information or otherwise account for disclosures of Protected Health Information made (i) for the purpose of Insurer's treatment activities, payment activities, or health care operations, as applicable; (ii) to the individual who is the subject of the Protected Health Information disclosed or to that individual's personal representative; or (iii) pursuant to a written authorization from the affected individual.

c) Disclosure Tracking Time Periods

Business Associate must have available for Insurer the disclosure information required by Section B.3(a), above, for the 6 years preceding Insurer's request for the disclosure information or any longer time period prescribed by applicable law.

4. Restriction Agreements and Confidential Communications

Business Associate will comply with any agreements that Insurer makes that either (i) restrict use or disclosure of Protected Health Information, or (ii) require confidential communication about Protected Health Information, provided that Insurer notifies Business Associate in writing of the restrictions or confidential communication obligations that Business Associate must follow and furnishes Business Associate copies of the agreements. Insurer will promptly notify Business Associate in writing of the termination of any such restriction agreement or confidential communication requirement and, with respect to termination of any such restriction agreement, instruct Business Associate whether any of Insurer's Protected Health Information will remain subject to the terms of the restriction agreement.

5. Inspection of Books and Records

Business Associate will make its internal practices, books, and records, relating to its use and disclosure of the Protected Health Information it creates or receives for or from Insurer, available to Insurer. Business Associate shall make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Insurer available to the Secretary, upon request, for purposes of determining and facilitating Insurer's compliance with HIPAA.

C. Breach of Privacy or Security Obligations.

1. Reporting

Business Associate will report to Insurer in writing any acquisition, access, use or disclosure of Unsecured Protected Health Information not permitted by this Addendum ("Security Breach") or any Security Incident of which Business Associate becomes aware. Business Associate will make the report to Insurer within 24 hours after Business Associate knows or should have reasonably known of such Security Breach or Security Incident. Business Associate will cooperate promptly with Insurer as is reasonably required for Insurer to comply with applicable breach reporting and notification laws ("Breach Notification Laws"). Business Associate's report will, to the extent possible:

a) Identify the nature of the Security Breach or Security Incident;

b) Identify the individuals (by full name and address) whose Unsecured Protected Health Information was, or is reasonably believed by Business Associate to have been, subject to a Security Breach and the total number of those individuals;

c) Identify the Unsecured Protected Health Information subject to the Security Breach or Security Incident;

d) Identify who committed the Security Breach or Security Incident and who acquired, accessed, used or received the Unsecured Protected Health Information;

e) Identify what corrective action Business Associate took or will take to prevent further Security Breaches or Security Incidents;

f) Identify what Business Associate did or will do to mitigate any deleterious effect of any Security Breaches or Security Incidents; and

g) Provide such other information as Insurer may reasonably request.

Insurer acknowledges the ongoing existence and occurrence of ordinary attempted but Unsuccessful Security Incidents which shall not constitute a Security Incident or Security Breach and shall not require Business Associate to provide notice to Insurer (and if notice is required, this provision shall be deemed to provide notice to Insurer of such Unsuccessful Security Incidents).

2. Termination of Addendum.

a) Right to Terminate for Breach of Addendum.
Insurer may terminate the Agent/Agency Contract if it determines, in its sole discretion, that Business Associate has breached any provision of this Addendum. Insurer may exercise this right to terminate the Agent/Agency Contract by providing Business Associate written notice of termination, stating the breach of this Addendum that provides the basis for the termination. Any such termination will be effective immediately or at such other date specified in the notice of termination.

b) Obligations upon Termination.

(i) Return or Destruction
Upon termination, cancellation, expiration or other conclusion of the Agent/Agency Contract, Business Associate will, as directed by Insurer, return to Insurer or destroy all Protected Health Information, in whatever form or medium (including in any electronic medium under Business Associate's custody or control), that Business Associate created or received for or from Insurer, including all copies of and any data or compilations derived from and allowing identification of any individual who is a subject of the Protected Health Information. Business Associate will complete such return or destruction as promptly as possible, but not later than 30 days after the effective date of the termination, cancellation, expiration or other conclusion of Agent/Agency Contract. If Insurer authorizes Business Associate to retain certain Protected Health Information because the Business Associate has a need for continued use or disclosure of that Protected Health Information, the Business Associate will identify that Protected Health Information and will limit its further use or disclosure to those necessary uses or disclosures. Within 30 days, Business Associate will certify an oath in writing to Insurer that such return or destruction has been completed, will deliver to Insurer the identification of any Protected Health Information for which return or destruction is infeasible and, for that Protected Health Information, will certify that it will

only use or disclose such Protected Health Information for those purposes that make return or destruction infeasible.

(ii) Continuing Privacy Obligation
Business Associate's obligation to protect the privacy of the Protected Health Information it created or received for or from Insurer will be continuous and survive termination, cancellation, expiration or other conclusion of the Agent/Agency Contract.

(iii) Other Obligations and Rights
Business Associate's other obligations and rights and Insurer's obligations and rights upon termination, cancellation, expiration or other conclusion of the Agent/Agency Contract will be those set out in the Agent/Agency Contract.

D. General Provisions

1. **Defined Terms.** For purposes of this Addendum, capitalized terms used but not otherwise defined in this Addendum shall have the same meaning as those terms in 45 CFR Parts 160 and 164. The following capitalized terms have the assigned meanings: "Protected Health Information" shall have the meaning set forth in 45 CFR § 164.103, limited however, to the information that Business Associate creates, accesses, or receives on behalf of Insurer (PHI includes EPHI); "Electronic Protected Health Information" or "EPHI" shall have the meaning set forth in 45 CFR § 160.103, limited however, to the information that Business Associate creates, accesses, or receives on behalf of Insurer; "Unsecured Protected Health Information" shall have the meaning set forth in 45 CFR § 164.402, limited however, to the information that Business Associate creates, accesses, or receives on behalf of Insurer; "Security Breach" has the meaning provided in Section C.1 of this Addendum; "Security Incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of, or interference with operations to process and maintain, EPHI, except to the extent that such action constitutes a Security Breach or an "Unsuccessful Security Incident"; "Unsuccessful Security Incidents" shall include, but not be limited to, phishing, pings and other broadcast attacks on Business Associate's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, so long as no such incident results in unauthorized access, use or disclosure of Protected Health Information; and "Secretary" shall mean the Secretary of the Department of Health and Human Services.
2. **Survival.** The terms of Section B.3 ("Disclosure Accounting"), Section B.5 ("Inspection of Books and Records"), Section C.1 ("Reporting"), and Section C.2 ("Obligations upon Termination") shall survive the termination or expiration of this Addendum.
3. **Conflicts.** The terms and conditions of this Addendum will override and control any conflicting term or condition of the Agent/Agency Contract. All non-conflicting terms and conditions of the Agent/Agency Contract remain in full force and effect.
4. **No Third-Party Beneficiaries.** Nothing express or implied in this Addendum is intended to confer, nor shall anything herein confer, upon any person other than the Insurer, Business Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.
5. **Ownership.** Nothing express or implied in this Addendum is intended to confer upon Business Associate any property rights to Protected Health Information.
6. **Interpretation.** Any ambiguity in this Addendum will be resolved in favor of a meaning that permits Insurer to comply with HIPAA.
7. **Amendment**. The parties acknowledge that this Addendum may be amended from time to time at Insurer's discretion and without prior notice to Business Associate.

US.357705267.02