



PRODUCER APPLICATION AND PRODUCER AGREEMENT SIGNATURE PAGE

I. APPLICANT INFORMATION

I elect to be appointed to  Pan-American Life Insurance Company
 Pan-American Casualty Company (Must possess a P&C license)

Application Type: Individual NPN Number: \_\_\_\_\_

Entity NPN Number: \_\_\_\_\_

First Name: \_\_\_\_\_ M: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_ SSN: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Driver's License No: \_\_\_\_\_ DL State: \_\_\_\_\_

Firm/Entity Name: \_\_\_\_\_ Tax ID No: \_\_\_\_\_

Type of Entity:

DBA's: \_\_\_\_\_

Business Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address:

Business Phone No: \_\_\_\_\_ Cell: \_\_\_\_\_ Fax: \_\_\_\_\_

\*E&O Coverage Carrier: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Coverage Amount (at least \$1M required): \$ \_\_\_\_\_ Exp. Date: \_\_\_\_\_

\* Please attach copy of your E&O insurance declaration page.

State License Information - Please list states you plan on soliciting business only\*\*

Table with 6 columns: Type, Individual/Entity, State, License #, Effective Date, Expiration Date. Multiple rows for listing states.

\*\*If you are being appointed in more states that the spaces provided, please attach information to application.

Are you seeking a Non-Resident Florida appointment? If yes, please list counties below:

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**II. BACKGROUND INFORMATION**

For agency or marketer applications, “you” refers to the entity, its principals, and its employees.

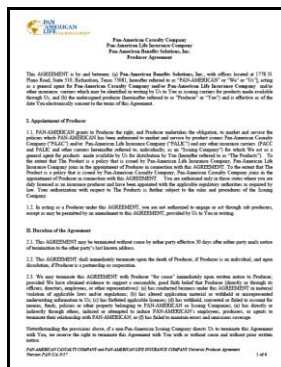
**\*\* Any inaccuracies in this section may be a basis for declination \*\***

1. Have you previously applied or requested to be contracted with **Pan-American Casualty Company, Pan-American Life Insurance Company, or their affiliates?**
  
2. Have you (a) ever filed for bankruptcy or been declared bankrupt, (b) any unsatisfied judgments or liens against you, or (c) ever been convicted of, pled guilty or nolo contendere to, or are you currently under indictment or investigation for any felony or misdemeanor?
  
3. Have you ever had an insurance or securities license canceled, revoked, or suspended or been disqualified or disciplined as a member of any profession?
  
4. Are you currently a party to any litigation or the subject of any investigation?
  
5. Have you ever been permitted to resign or surrender a license, been discharged or been terminated after you were accused of fraud, theft, misrepresentation, misappropriation, breach of fiduciary duty, or failure to supervise in connection with insurance or investment related activities or other wrong doing?
  
6. Have you ever been subject to an ERISA, insurance or investment related consumer or employer initiated complaint or proceeding that alleged or found fraud, sales practice violation, forgery, theft, misappropriation or conversion?

*\* If you answered "Yes" to any of these questions, please attach a letter of explanation.*

**III. EXECUTION OF PRODUCER AGREEMENT**

By initialing below, I have read and agree to abide by the [Pan-American Benefits Solutions Producer Agreement](#) that has been provided with this application; a copy is also available by clicking on the document below.



Initial

Date

**PRODUCER APPLICATION AND PRODUCER AGREEMENT SIGNATURE PAGE****IV. FORM W-9 TAXPAYER INFORMATION**

Does the information shown in **Section I** match the information on your tax return?

If **YES**, read statement below. Initial and date.

**Under penalty of perjury, I certify that**

- My social security number and tax identification information is correct;
- 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 (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
- I am a U.S. citizen or other U.S. person under the federal tax code (such as a U.S. resident alien or a partnership, corporation, company, or association created or organized in the United States or under the laws of the United States).

\_\_\_\_\_  
Initial

\_\_\_\_\_  
Date

\* If **“No”**, a separate **Form W-9** must be completed and attached to this application. Click [here](#) for the form.

**V. APPLICATION SIGNATURE AND AUTHORIZATION, by initialing and dating the boxes below I hereby:**

- Give consent for **Pan-American Casualty Company, Pan-American Life Insurance Company or any of their affiliates** to use this information where its legal interest and/or obligations are involved;
- Certify this information is correct, complete and agree to report immediately any changes in the information in this application;
- Understand providing inaccurate or incomplete information is grounds for declination or termination;
- Understand I have no right to commission or other compensation unless and until **Pan-American Casualty Company, Pan-American Life Insurance Company or any of their affiliates** approves this application in writing and **Pan-American Casualty Company or Pan-American Life Insurance Company** has completed any necessary regulatory appointments;
- Agree I have no authority to and will not obligate or bind **Pan-American Casualty Company or Pan-American Life Insurance Company or any of their affiliates** on a policy, risk, or any other contract or expense; and
- Certify I have not been convicted of a crime that would disqualify me from association with **Pan-American Casualty Company or Pan-American Life Insurance Company or any of their affiliates** under the Violent Crime Control Act and/or Employee Retirement Income Security Act.

\_\_\_\_\_  
Initial

\_\_\_\_\_  
Date

A copy of the [Pan-American Benefits Solutions Producer Agreement](#) and the [Compliance Guide](#) is available for download at the highlighted links above. **Please retain a copy for your records.**

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**VI. PRODUCER QUESTIONNAIRE**

- What is the #1 product and/or service you plan on adding to your product portfolio? \_\_\_\_\_  
\_\_\_\_\_
- What is the primary revenue source of your agency? \_\_\_\_\_
- What are the top three characteristics you require or desire of your Carrier partners?
  - 1) \_\_\_\_\_
  - 2) \_\_\_\_\_
  - 3) \_\_\_\_\_

**Please indicate your Areas of Practice below:**

- | Group Products                                      | Individual Products                                 | Property & Casualty Commercial Lines                        |
|---|---|---|
| <input type="checkbox"/> Major Medical              | <input type="checkbox"/> Major Medical              | <input type="checkbox"/> Occupational Accident (TX)         |
| <input type="checkbox"/> Minimum Essential Coverage | <input type="checkbox"/> Minimum Essential Coverage | <input type="checkbox"/> Trucking Occupational Accident     |
| <input type="checkbox"/> Minimum Value              | <input type="checkbox"/> Minimum Value              | <input type="checkbox"/> Workers' Compensation              |
| <input type="checkbox"/> Self-Funded                | <input type="checkbox"/> Critical Illness           | <input type="checkbox"/> Business Travel Accident           |
| <input type="checkbox"/> Large Group                | <input type="checkbox"/> Cancer                     | <input type="checkbox"/> General Liability                  |
| <input type="checkbox"/> Small Group                | <input type="checkbox"/> Short/Long Term Disability | <input type="checkbox"/> E&O                                |
| <input type="checkbox"/> Limited Medical            | <input type="checkbox"/> Dental                     | <input type="checkbox"/> Other _____                        |
| <input type="checkbox"/> Critical Illness           | <input type="checkbox"/> Accident                   |   |
| <input type="checkbox"/> Cancer                     | <input type="checkbox"/> Limited Medical            |   |
| <input type="checkbox"/> Short/Long Term Disability | <input type="checkbox"/> Life                       | <b>Property &amp; Casualty Personal Lines</b>               |
| <input type="checkbox"/> Dental                     | <input type="checkbox"/> Vision                     | <input type="checkbox"/> Personal Lines Property & Casualty |
| <input type="checkbox"/> Accident                   | <input type="checkbox"/> Retirement                 |   |
| <input type="checkbox"/> Life                       | <input type="checkbox"/> Worksite Marketing         |   |
| <input type="checkbox"/> Vision                     | <input type="checkbox"/> Medicare                   |   |
| <input type="checkbox"/> Retirement                 | <input type="checkbox"/> Medicare Supplement        |   |
| <input type="checkbox"/> Worksite Marketing         | <input type="checkbox"/> Marketplace/Exchange       |   |
| <input type="checkbox"/> Other _____                | <input type="checkbox"/> Other _____                |   |

**VII. SUBMISSION**

The applicant may submit this form and attachments via [email](#). By submitting this form to **Pan-American Casualty Company and Pan-American Life Insurance Company**, the applicant is indicating intent to be bound by the statements and assertions set forth in this document. If you have any questions, please contact your Company Representative.

You **must** attach a copy of the following:

- **E&O insurance declaration page** (declaration page must reflect the applicant's name, carrier name, expiration date, deductible, insuring limits, and coverage amount). If the individual's name is not listed on the certificate, please include a letter stating they are covered on this policy.
- Signed copy of the attached **FCRA Authorization** form.
- If necessary, a **Letter of Explanation** for any "Yes" answer in **Section II**.
- If you answered "No" in **Section IV**, a completed **Form W-9**.

**\*\*\* Your application will not be processed until all the required documents are submitted \*\*\***

**To submit the application, click on the Submit button below.**