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CALIFORNIA

# SHOP Agent Certification Process



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## SHOP Agent Agreement

**You went to class, completed the online training,  
passed the exam...**

*Now what?*



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## SHOP Agent Agreement

Dear Agent,

Congratulations on your recent completion of the Covered California Certified Insurance Agent Training and Examination. Below are the final steps required to become a Certified Insurance Agent.

Download the file containing the required documents here:

<http://coveredcaagent.pinnacletpa.com/agentforms/agentagreement.zip>

### **STEP 1**

Submit Required Documents.

**via email** (with scanned documents attached):

[agents@covered.ca.gov](mailto:agents@covered.ca.gov)

or

**via U.S. mail:**

Covered California

P.O. Box 7010

Newport Beach, CA 92658



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## SHOP Agent Agreement

### STEP 2

Pay Agent Endorsement Fee of \$58.25 online at <https://coveredcaagent.pinnacletpa.com/agentpayment/>. This fee is used to pay for your endorsement by Covered California with the California Department of Insurance. You will be able to print a receipt from the website as well as receive an email confirmation of your payment.



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## Covered California – JOB AID: SHOP Agent Certification E&E Process

### **NEXT STEPS**

Once the Covered California Service Center verifies all the required documents and confirms payment of the Endorsement Fee, the following will happen. Your status on CoveredCA.com will be updated to “Certified”. You will receive an email notification that you have a message in your secure inbox within 5-7 days. This message will be a confirmation of your status change. Once certified, consumers can find you on CoveredCA.com and you can officially represent Covered California. You will also be able to update and edit your Covered California public facing profile.

Covered California will update the California Department of Insurance (CDI) website with your endorsement information. This fulfills a requirement by CDI and provides another place where consumers can verify your certified status with Covered California.



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# SHOP Agent Agreement

Highlighted fields must be completed by agent in all of the following documents

STATE OF CALIFORNIA  
**STANDARD AGREEMENT**  
STD 213 (Rev 06/03)

|                                  |
|----------------------------------|
| AGREEMENT NUMBER<br><b>A-13-</b> |
| REGISTRATION NUMBER              |

- This Agreement is entered into between the State Agency and the Contractor named below:  
STATE AGENCY'S NAME  
California Health Benefit Exchange  
CONTRACTOR'S NAME  
[Redacted]
- The term of this Agreement is: From the Date Signed by the State below for one (1) year from said Date.
- The maximum amount of this Agreement is: Undefined
- The parties agree to comply with the terms and conditions of the following exhibits which are by this reference made a part of the Agreement.

|  |          |
|--|----------|
| Exhibit A – Scope of Work                        | 11 Pages |
| Exhibit B – Budget Detail and Payment Provisions | 3 Pages  |
| Exhibit C – General Terms and Conditions         | 17 Pages |
| Exhibit D – Business Associates Agreement        | 12 Pages |
| Exhibit E – Branding Guidelines                  | 3 Pages  |
| Exhibit F – Schedule of Commissions              | 1 Pages  |
| Exhibit G – Darfur Certification                 | 1 Pages  |

**IN WITNESS WHEREOF, this Agreement has been executed by the parties hereto.**

|  |   |  |
|--|---|--|
| <b>CONTRACTOR</b>  |   | <i>California Department of General Services Use Only</i>                                    |
| CONTRACTOR'S NAME (if other than an individual state whether a corporation, partnership, etc.)<br>[Redacted] |   |  |
| BY (Authorized Signature)<br>[Redacted]  | DATE SIGNED (Do not type)<br>[Redacted] |  |
| PRINTED NAME AND TITLE OF PERSON SIGNING<br>[Redacted]   |   |  |
| ADDRESS<br>[Redacted]  |   |  |
| <b>STATE OF CALIFORNIA</b>   |   |  |
| AGENCY NAME<br>California Health Benefit Exchange  |   | <input checked="" type="checkbox"/> Exempt per:<br><b>Government Code<br/>Section 100505</b> |
| BY (Authorized Signature)<br>[Redacted]  | DATE SIGNED (Do not type)<br>[Redacted] |  |
| PRINTED NAME AND TITLE OF PERSON SIGNING<br>David Maxwell-Jolly, Chief Deputy Executive Director, Strategy   |   |  |
| ADDRESS<br>560 J Street, Suite 290, Sacramento, CA 95814   |   |  |



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# SHOP Agent Agreement

## Section 1

---

1. This Agreement is entered into between the State Agency and the Contractor named below:

STATE AGENCY'S NAME

California Health Benefit Exchange

CONTRACTOR'S NAME

**Your Name Here**

Throughout the contract your name should appear when “contractor name” appears.  
This field is specific to you, the agent, not an agency.



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# SHOP Agent Agreement

IN WITNESS WHEREOF, this Agreement has been executed by the parties hereto.

|   |   |  |
|---|---|--|
| <b>CONTRACTOR</b>   |   | <i>California Department of General Services Use Only</i>                                    |
| CONTRACTOR'S NAME (if other than an individual, state whether a corporation, partnership, etc.)<br>[Redacted] |   |  |
| BY (Authorized Signature)<br>[Signature]  | DATE SIGNED (Do not type)<br>[Redacted] |  |
| PRINTED NAME AND TITLE OF PERSON SIGNING<br>[Redacted]  |   |  |
| ADDRESS<br>[Redacted]   |   |  |
| <b>STATE OF CALIFORNIA</b>  |   |  |
| AGENCY NAME<br>California Health Benefit Exchange   |   | <input checked="" type="checkbox"/> Exempt per:<br><b>Government Code<br/>Section 100505</b> |
| BY (Authorized Signature)<br>[Signature]  | DATE SIGNED (Do not type)<br>[Redacted] |  |
| PRINTED NAME AND TITLE OF PERSON SIGNING<br>David Maxwell-Jolly, Chief Deputy Executive Director, Strategy    |   |  |
| ADDRESS<br>560 J Street, Suite 290, Sacramento, CA 95814  |   |  |



# SHOP Agent Agreement

California Health Benefit Exchange

Page 1 of 11

## EXHIBIT A (Agent Agreement)

### SCOPE OF WORK

This Agreement is made between the State of California, acting by and through the California Health Benefit Exchange, hereafter referred to as the "Exchange" and [redacted] an individual licensed by the California Department of Insurance to transact in health insurance and acting pursuant to the laws of the State of California, hereafter referred to as "Agent" or "Contractor" interchangeably.

Agent as it appears on license:

License Number/Expiration:

Federal ID number or SSN:

Business Phone:

Business Fax:

Email address:

[Redacted form fields for license number, expiration date, federal ID/SSN, business phone, business fax, and email address.]

### A. Purpose:

The mission of the Exchange is to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value.



# SHOP Agent Agreement

## EXHIBIT G (Agent Agreement)

### DARFUR CONTRACTING ACT CERTIFICATION FORM

Pursuant to Public Contract Code section 10478, if a contractor within the previous three years has had business activities or other operations outside of the United States, it must certify that it is not a "scrutinized" company as defined in Public Contract Code section 10476.

Therefore, please insert your name and Federal ID Number or SSN and complete only one of the following three paragraphs (via initials for Paragraph # 1 or Paragraph # 2, or via initials and certification for Paragraph # 3):

|   |                              |
|---|------------------------------|
| <i>Agent Name (Printed)</i>   | <i>Federal ID Number/SSN</i> |
|   |                              |
| <i>Printed Name and Title of Person Initialing (for Options 1 or 2)</i> |                              |
|   |                              |

- \_\_\_\_  
Initial
1. We/I do not currently have, and have not had within the previous three years, business activities or other operations outside of the United States.
- OR
- \_\_\_\_  
Initial
2. We/I are a scrutinized company as defined in Public Contract Code section 10476, but we have received written permission from the Department of General Services to participate in the Exchange proposal pursuant to Public Contract Code section 10478. A copy of the written permission from DGS has been sent to the Exchange.
- OR
- \_\_\_\_  
Initial
3. We currently have, or we have had within the previous three years, business activities or other operations outside of the United States, certification but we certify below that we are not a scrutinized company below as defined in Public Contract Code section 10476.
- CERTIFICATION FOR #3**

**Initial the ONE box that applies to you**



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# SHOP Agent Agreement

OR

            
Initial

3. ~~We currently have, or we have had within the previous three~~  
operations outside of the United States, certification but we  
scrutinized company below as defined in Public Contract C

CERTIFICATION For # 3.

I, the official named below, CERTIFY UNDER PENALTY OF  
authorized to legally bind the prospective proposer/bidder to the clause listed above in # 3. This  
certification is made under the laws of the State of California.

**If #3 applies, fill out  
the certification box**

|   |  |
|---|--|
| <i>By (Authorized Signature)</i><br>[Redacted]                |  |
| <i>Printed Name and Title of Person Signing</i><br>[Redacted] |  |
| <i>Date Executed</i><br>[Redacted]                            | <i>Executed in the County and State of</i><br>[Redacted] |



# SHOP Agent Agreement

## Payee Data Record (Standard 204 form) Section 2

STATE OF CALIFORNIA-DEPARTMENT OF FINANCE

### PAYEE DATA RECORD

(Required when receiving payment from the State of California in lieu of IRS W-9)

STD. 204 (Rev. 6-2003)

|                       |  |                  |
|-----------------------|--|------------------|
| <b>1</b>              | <b>INSTRUCTIONS:</b> Complete all information on this form. Sign, date, and return to the State agency (department/office) address shown at the bottom of this page. Prompt return of this <b>fully completed</b> form will prevent delays when processing payments. Information provided in this form will be used by State agencies to prepare Information Returns (1099). See reverse side for more information and Privacy Statement.<br><b>NOTE:</b> Governmental entities, federal, State, and local (including school districts), are not required to submit this form. |                  |
| <b>2</b>              | PAYEE'S LEGAL BUSINESS NAME (Type or Print)  |                  |
|                       | [Redacted]   |                  |
|                       | SOLE PROPRIETOR – ENTER NAME AS SHOWN ON SSN (Last, First, M.I.)   | E-MAIL ADDRESS   |
|                       | [Redacted]   | [Redacted]       |
|                       | MAILING ADDRESS  | BUSINESS ADDRESS |
| [Redacted]            | [Redacted]   |                  |
| CITY, STATE, ZIP CODE | CITY, STATE, ZIP CODE  |                  |
| [Redacted]            | [Redacted]   |                  |



# SHOP Agent Agreement

## Payee Data Record (Standard 204 form)

### Section 2

STATE OF CALIFORNIA-DEPARTMENT OF FINANCE  
**PAYEE DATA RECORD**  
(Required when receiving payment from the State of California in lieu of IRS W-9)  
STD. 204 (Rev. 6-2003)

|                       |   |                  |
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| <b>1</b>              | <b>INSTRUCTIONS:</b> Complete all information on this form. Sign, date, and return to the State agency (department/office) address shown at the bottom of this page. Prompt return of this fully completed form will prevent delays when processing payments. Information provided in this form will be used by State agencies to prepare Information Returns (1099). See reverse side for more information and Privacy Statement.<br><b>NOTE:</b> Governmental entities, federal, State, and local (including school districts), are not required to submit this form. |                  |
| <b>2</b>              | PAYEE'S LEGAL BUSINESS NAME (Type or Print)   |                  |
|                       | [Redacted]  |                  |
|                       | SOLE PROPRIETOR – ENTER NAME AS SHOWN ON SSN (Last, First, M.I.)  | E-MAIL ADDRESS   |
|                       | [Redacted]  | [Redacted]       |
|                       | MAILING ADDRESS   | BUSINESS ADDRESS |
| [Redacted]            | [Redacted]  |                  |
| CITY, STATE, ZIP CODE | CITY, STATE, ZIP CODE   |                  |
| [Redacted]            | [Redacted]  |                  |

- Section 2 payee information can be agent or agency
    - Must match your online profile\*
- \*If the information on this form is different than that entered in your online profile, you will have the ability to change your online profile once certification is complete to match this information.





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## SHOP Agent Agreement

Payee Data Record (Standard 204 form)

Section 4

|          |   |
|----------|---|
| <p>4</p> | <p><input type="checkbox"/> California resident - Qualified to do business in California or maintains a permanent place of business in California.</p> <p><input type="checkbox"/> California nonresident (see reverse side) - Payments to nonresidents for services may be subject to State income tax withholding.</p> <ul style="list-style-type: none"><li><input type="checkbox"/> No services performed in California.</li><li><input type="checkbox"/> Copy of Franchise Tax Board waiver of State withholding attached.</li></ul> |
|----------|---|



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## SHOP Agent Agreement

Payee Data Record (Standard 204 form)

Section 5

|   |  |           |       |
|---|--|-----------|-------|
| 5 | I hereby certify under penalty of perjury that the information provided on this document is true and correct.<br>Should my residency status change, I will promptly notify the State agency below. |           |       |
|   | AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print)   |           | TITLE |
|   | SIGNATURE  |           | DATE  |
|   |  | TELEPHONE | ( )   |

If the payee is an agency, authorized agency representative must sign section 5



# SHOP Agent Agreement

Payee Data Record (Standard 204 form)  
Section 6

|  |                                     |                               |
|--|-------------------------------------|-------------------------------|
| <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; line-height: 20px;">6</div> | Please return completed form to:    |                               |
|  | Department/Office:                  | <input type="text"/>          |
|  | Unit/Section:                       | <input type="text"/>          |
|  | Mailing Address:                    | <input type="text"/>          |
|  | City/State/Zip:                     | <input type="text"/>          |
|  | Telephone: ( ) <input type="text"/> | Fax: ( ) <input type="text"/> |
|  | E-mail Address:                     | <input type="text"/>          |

Section 6 may be left blank



# SHOP Agent Agreement

## E&O Certificate of Insurance

- Named Insured can be the agency if the agency is listed as the agents business name in online profile.
- Minimum coverage is \$1 mil
- Contract must be current

| CERTIFICATE OF INSURANCE  |                    |   |                        |  |
|---|--------------------|---|------------------------|--|
| NOTICE:   |                    |   |                        |  |
| <p>THIS INSURANCE PROVIDES COVERAGE ON A CLAIMS-MADE AND REPORTED BASIS AND, SUBJECT TO THE PROVISIONS OF THE POLICY, APPLIES ONLY TO ANY CLAIM FIRST MADE AGAINST AN INSURED AND REPORTED TO THE INSURER IN ACCORDANCE WITH SECTION VII, NOTICE. NO COVERAGE EXISTS FOR CLAIMS FIRST MADE AFTER THE END OF THE CERTIFICATE PERIOD UNLESS, AND TO THE EXTENT THAT, THE EXTENDED REPORTING PERIOD APPLIES. DEFENSE COSTS REDUCE THE LIMIT OF LIABILITY AND ARE SUBJECT TO THE RETENTION. PLEASE REVIEW THE POLICY CAREFULLY AND DISCUSS THE COVERAGE WITH YOUR INSURANCE AGENT OR BROKER.</p> <p>THIS CERTIFICATE OF INSURANCE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND, OR ALTER THE COVERAGE AFFORDED BY THE INSURANCE POLICY.</p> |                    |   |                        |  |
| NAMED INSURED:  |                    | PRODUCER: Marsh U.S. Consumer<br>a service of Seabury & Smith, Inc.<br>P.O. Box 8146<br>Des Moines, IA 50306-8146<br>1-866-795-2041 |                        |  |
| COMPANY AFFORDING COVERAGE: Continental Casualty Co.  |                    |   |                        |  |
| <p><b>COVERAGE</b><br/>THIS IS TO CERTIFY THAT THE INSURED LISTED ABOVE IS COVERED UNDER THE POLICY OF INSURANCE LISTED BELOW, FOR THE CERTIFICATE PERIOD INDICATED. THE INSURANCE AFFORDED BY THE POLICY DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICY.</p>   |                    |   |                        |  |
| Policy Number   | Certificate Number | Certificate Period  |                        | Limits of Liability  |
|   |                    | <i>Effective Date</i>   | <i>Expiration date</i> | \$ 1,000,000 Each Claim<br>\$ 1,000,000 Aggregate *  |
| 425236695   | RIA1447            | 12/01/2012  | 12/01/2013             | <p>* This policy is also subject to a Policy Year aggregate limit of liability of \$15,000,000. The Policy Year aggregate limit of liability will be reduced by claims paid on behalf of a Insureds under the policy, including you.</p> <p>The Policy Year aggregate limit includes the total per claim/aggregate limits of the insurer regardless of the total number of Insureds under the Policy, the total number of Certificate of Insurance issued under the policy, or persons or entities bringing such Claims.</p> |



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## SHOP Agent Agreement

### **Upon receipt of your documents**

- Review for completeness
- Validate that your payment was made
- Process in the order received
- Update your status to “certified”
- Update CDI with endorsement
- Notify you of your status change\*

\*Processing times are subject to change based on volume of applications received



# SHOP Agent Agreement

## Incomplete Application Message

Dear Agent,

We have received your documents, however the below document was not complete or is missing and is required for certification. This issue can be resolved.

Send to the Service Center a revised [enter document name here] form.

Send to [Agents@covered.ca.gov](mailto:Agents@covered.ca.gov)

Or mail to:

Covered California

P.O. Box 7010

Newport Beach, CA 92658

Your certification status will remain in an Eligible, non-Certified status until this matter is resolved.

Incomplete or missing information will result in delays to the certification process



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# SHOP Agent Agreement

Or.....



# SHOP Agent Agreement

## Successful Application Message

Congratulations!

You have completed all of the steps required to become a Covered California Certified Insurance Agent. Now that you are certified you may log in to your agent portal at [CoveredCA.com](http://CoveredCA.com) and edit your profile. To login you will use the username and password that you created at the beginning of the agent registration process. Please note that this is a different login than the one used for the Learning Management System.

As a Covered California Certified Insurance Agent your profile is accessible to millions of Californians who are newly eligible to benefit from coverage through Covered California. These consumer can find you and delegate you as their agent by choosing "Find Help Near You".