



**COVERED
CALIFORNIA**

Agent Agreement Renewal

Autumn 2014



Webinar Description

The purpose of the *Agent Agreement Renewal* webinar is to provide an overview of the changes to the Agent Agreement and how to respond to the Agreement Package sent to Certified Insurance Agents.

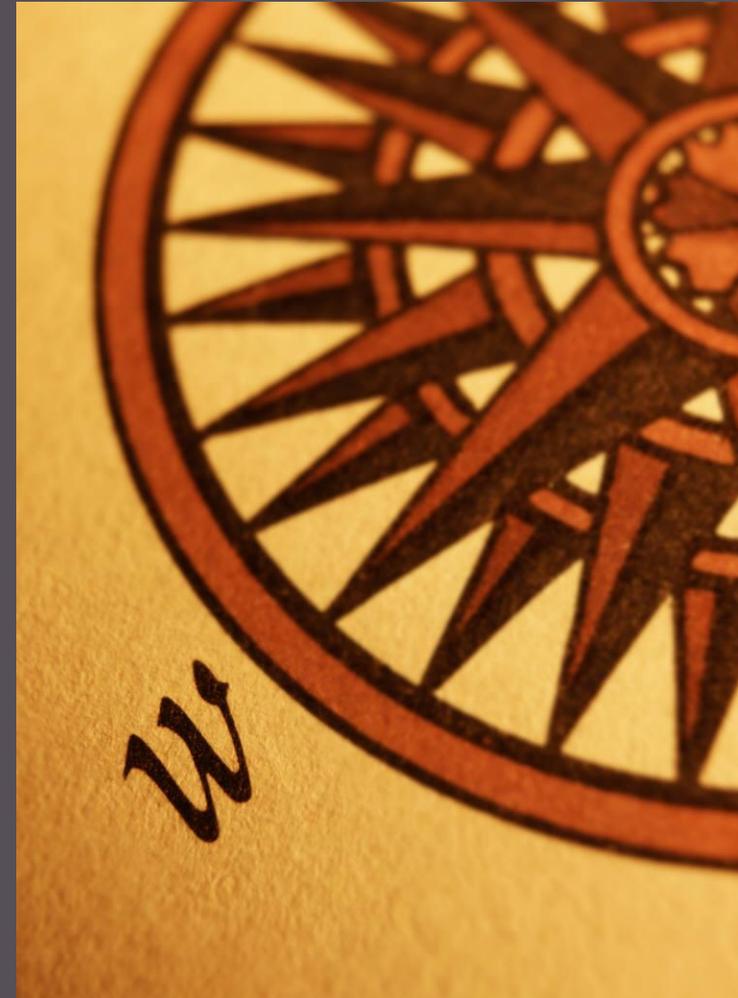




Webinar Outline

The ***Agent Agreement Renewal*** webinar contains the following lessons:

- Overview
- Changes to the Agent Agreement
- The Agreement Package
- Payee Scenarios





Overview

- *Timeline*
- *Email from DocuSign®*
- *The Agreement Package*
- *The Agreement Documents*





Timeline

- Beginning the week of September 22nd, 2014, Covered California will begin sending new Agent Agreements by email for signature.
- Agreements will continue to be distributed through October and will be sent to agents based on the expiration date of their certification, with agents whose certifications are set to expire at the end of September receiving the document first.





Email from DocuSign®

Monday



Covered California via DocuSign

Mon 2:38 PM

- The new Agent Agreement package will be sent in an e-mail from DocuSign®, on Covered California's behalf, with instructions for signing and returning it back to Covered California.
- All Certified Insurance Agents will be required to sign and return the updated Agreement within 45 days of receipt in order to renew their certification.



The Agreement Package

The Agreement Package includes four documents:

- Instructions - Agent Agreement Renewal.pdf
- Payee Data Record 204.pdf
- Standard Agreement 213.pdf
- Agent Agreement Exhibits.pdf





The Agreement Documents

STATE OF CALIFORNIA-DEPARTMENT OF FINANCE
PAYEE DATA RECORD
(Required when receiving payment from the
STD. 204 (Rev. 6-2003))

1	INSTRUCTIONS: Complete the bottom of this page. This form will be used by the State to prepare your Statement. NOTE: Governmental entities are exempt from this form.
2	PAYEE'S LEGAL BUSINESS TYPE SOLE PROPRIETOR – E MAILING ADDRESS CITY, STATE, ZIP CODE
3	ENTER FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN) PAYEE ENTITY TYPE <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> ESTATE OR TRUST

- The Payee Data Record 204 and the Standard Agreement 213 will be pre-populated based on the information in your Covered California agent portal
- Review these forms for accuracy before submitting your signed Agent Agreement
- You will have the opportunity to change some of those pre-populated fields on Form 204
- You will also be prompted to enter new information
- These changes and additions will be automatically reflected on Form 213



Changes to the Agent Agreement

- *Changes to Regulations*
- *Changes to the Agent Agreement*





Changes to Regulations

Section 6804, Agent Certification Application

- Changes Administrative fee from \$10.25 to \$12.00.

Section 6806, Training Standards

- Removes the requirement of four (4) hours of Continuing Education Training for recertification.
- Clarifies that Agent must maintain knowledge on specific related subjects as required by the California Department of Insurance (CDI).



Changes to Agreement – Exhibit A

Exhibit A – Scope of Work

- Covered California may increase the number of employees in a small employer to 100 (Section A)
- Agents are required to explain to all potential consumers about the availability of APTC and that APTC is only available through Covered California (Section C 6.c.)
- Agents to provide Voter Registration assistance to consumers when submitting an application, a renewal, or a change of address (Section C 7.a.)



Changes to Agreement – Voter Registration Assistance

- The application, both online and paper, contains a new voter registration preferences section.
- The Agent will ask the Consumer if he/she wants to register to vote.
- If the Consumer answers “Yes”, the registration can be completed online at <https://www.coveredca.com/resources/voter-registration/> or the Consumer can opt to receive the forms by mail.



Changes to Agreement – Exhibit A

Exhibit A – Scope of Work

- Agents may not accept payment or any other form of compensation from the Consumer for providing services outlined in this Agreement (Section C 8.a.)
- The requirement of four (4) hours of Continuing Education Training for recertification has been removed (Section C 15.b.)
- The Contract Term has been changed from one (1) to five (5) years (Section H)



Changes to Agreement – Exhibit B

Exhibit B – Budget Detail and Payment Provisions (Section A 3.)

- Agent Compensation for Medi-Cal Enrollment Assistance has been added
- Agents will receive payments for approved Medi-Cal applications from the 2014 Open Enrollment Period forward



Changes to Agreement – Exhibit C

Exhibit C – General Terms and Conditions of Use

- **Termination Without Cause title was changed to Vesting. Additionally, this section clarifies that the contract would not be terminated but could be suspended. (Section E 2.)**
- **Changed Audit provision from three (3) years to ten (10) years (Section M)**
- **Federal Terms and Conditions – this section was added in its entirety (Section U)**



Changes to Agreement – Exhibit D

Exhibit D – Business Associate Agreement removed and replaced with Privacy and Security Requirements

- This section was rewritten in its entirety to strengthen consumer protection and align with State and Federal Privacy and Security Laws, including fingerprinting and background checks for non-licensed agent support staff.



Changes to Agreement – Exhibit E

Exhibit E – Branding Guidelines

- Revisions and additions clarify and establish Agent requirements when using the Covered California Trademark and Brand. These revisions and additions were made to strengthen consumer protection.
- Changes to the Brand Style Guide to include Agent Color Logo



The Agreement Package

- *The DocuSign® Email*
- *Request for Signature*
- *Navigation*
- *Document Tags*
- *Sign Document Online*
- *Return Documents*





The DocuSign® Email

Please review and sign your document



From: Covered California (agents@covered.ca.gov)
Covered California

Hello Annie Smith,

Covered California has sent you a new DocuSign document to view and sign. Please click on the 'View Documents' link below to begin signing.

All Certified Insurance Agents are required to sign and return the updated Agent Agreement in order to renew their certification with Covered California.

You will have 45 business days to sign and return the new Agent Agreement. Failure to return the signed document within this timeframe may result in the termination of your contract with Covered California and/or the delay of future commission payments.

Please note that some sections of the Agent Agreement, including the STD Form 204 and 213, will be pre-populated based on the information in your Covered California agent portal. We ask that you review these forms for accuracy before submitting your signed Agent Agreement.

If you should need to make changes to your STD Form 204 or 213, please follow the instructions in DocuSign® to update the forms before submitting back to Covered California with your electronic signature.

The Agent Service Center at 877-453-9198 or via e-mail at agents@covered.ca.gov will be available to assist you with any questions you may have.

View Documents

Click

Contact DocuSign® at service@docusign.com if you have difficulties viewing these documents



Request for Signature

Request for Signature 

From:  **Covered California**
Pinnacle Claims Management Inc

Documents (4): Instructions - Agent Agreement Renewal.pdf
1 Payee Data Record 204.pdf
2 Standard Agreement 213.pdf
3 Agent Agreement Exhibits.pdf

ELECTRONIC RECORD AND SIGNATURE DISCLOSURE

From time to time, Pinnacle Claims Management Inc (we, us or Company) may be required by law to provide to you certain written notices or disclosures. Described below are the terms and conditions for providing to you such notices and disclosures electronically through your DocuSign, Inc. (DocuSign) Express user account. Please read the information below carefully and thoroughly, and if you can access this information electronically to your satisfaction and agree to these terms and conditions, please confirm your agreement by clicking the 'I agree' button at the bottom of this document.

[Read Electronic Record and Signature Disclosure >](#)

I consent to use Electronic Records and Signatures

Review Documents **Decline** **Finish Later** **Sign on Paper**

Select

Click



Navigation

Navigation Tags prompt you to move to the next page where you need to enter new information or sign the document

Circles indicate pages where you need to complete information or provide a signature

The **Menu** displays documents and pages



Document Tags

COVERED CALIFORNIA

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MAILING ADDRESS 123 Main Street Suite B		BUSINESS ADDRESS	
CITY, STATE, ZIP CODE CA 92614		CITY, STATE, ZIP CODE	
ENTER FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN):		NOTE: Payment will not be processed without an accompanying taxpayer I.D. number.	
3 PAYEE ENTITY TYPE CHECK ONE BOX ONLY	<input type="checkbox"/> PARTNERSHIP	CORPORATION:	
	<input type="checkbox"/> ESTATE OR TRUST	<input checked="" type="checkbox"/> MEDICAL (e.g., dentistry, psychotherapy, chiropractic, etc.) <input type="checkbox"/> LEGAL (e.g., attorney services) <input type="checkbox"/> EXEMPT (nonprofit) <input type="checkbox"/> ALL OTHERS	
<input checked="" type="checkbox"/> INDIVIDUAL OR SOLE PROPRIETOR ENTER SOCIAL SECURITY NUMBER: 112233446			
<small>(SSN required by authority of California Revenue and Tax Code Section 18646)</small>			
4 PAYEE RESIDENCY STATUS	<input checked="" type="checkbox"/> California resident - Qualified to do business in California or maintains a permanent place of business in California.		
	<input type="checkbox"/> California nonresident (see reverse side) - Payments with withholding. <input type="checkbox"/> No services performed in California. <input type="checkbox"/> Copy of Franchise Tax Board waiver of State income tax		
5 I hereby certify under penalty of perjury that the information provided is true and correct. Should my residency status change, I will promptly notify the State agency below.			
AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print) Annie Smith		TITLE	
SIGNATURE Sign Here		DATE 9/23/2014	TELEPHONE 7141234567

Editable

Required

Choose

Document Tags highlight what action needs to be completed

Not Editable



Document Tags - Example

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Exhibit A 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 [Annie Smith](#)

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 enters this contract For the Benefit of

Agent as it appears on license: [Annie Smith](#)

License Number/Expiration: [0A12345](#)

Federal ID number or SSN: [112233446](#)

Business Phone: [7141234567](#)

Business Fax:

Email address: [asmith@pin](#)

Please enter the date that your license expires. (MM/DD/YY)

Enter your Insurance License Expiration Date and your Business Fax Number. All other changes must be made on the Payee Data Record to be reflected here.

Fill In

You are prompted to enter your License Expiration Date



Sign Documents Online

Sign	AUTHORIZED PAYEE REPRESENTATIVE'S NAME Annie Smith
	SIGNATURE Sign Here

First, click on the field that requires signature

Then, confirm your name and initials

Adopt Your Signature

Confirm your name, initials, and signature.

Full Name: x Initials:

[Select Style](#) [Draw](#)

Preview

DocuSigned by:
Annie Smith
D61C81AC2E2041F...

DS
AS

[Change Style](#)

By clicking Adopt, I agree that the signature and initials will be the electronic representation of my signature and initials for all purposes, including legally binding contracts - just the same as a pen-and-ink signature.

Adopt and Sign

Select your signature style

Finally, select **Adopt and Sign**



Returned Signed Documents Online

Confirm Signing

All required fields complete.

You will have an opportunity to save your copy on the next screen.

Click "Confirm Signing" when you are ready.

Click Confirm Signing

Think that was easy?

It's just as easy to sign any document electronically, even if it wasn't sent through DocuSign. Sign up for a FREE account today!

Email

asmith@pinnacletpa.com

Password

Confirm Password

OR



By clicking the "Sign Up Now" button below, you agree to the Terms and Conditions

Sign Up Now

Click **Download** to download the signed documents to your computer or click **Print** to print these signed documents.

Download ↓ Print



Returned Signed Documents By Mail

stom Subject Line 9/10

100% Download Print More

First, click **Print** to print the *signed* documents

via U.S. Mail to:

**Covered California
P.O. Box 7010
Newport Beach, CA 92658**

Then, mail the *signed* documents to this address



Payee Scenarios

- *Scenario 1 – Payment to Agency*
- *Scenario 2 – Payment to Agent*
- *Help and Support*





Scenario 1 – Payment to Agency

The FEIN, the Legal Business Name, and the Business address will auto-populate

PAYEE DATA RECORD

(Required when receiving payment from the State of California in lieu of IRS W-9)
STD. 204 (Rev. 6-2003)

1

INSTRUCTIONS: Complete all information on this form. Sign, date, and return to the State agency (at the bottom of this page). Prompt return of this **fully completed** form will prevent delays when processing this form will be used by State agencies to prepare Information Returns (1099). See reverse side for more information.
NOTE: Governmental entities, federal, State, and local (including school districts), are not required to complete this form.

2

PAYEE'S LEGAL BUSINESS NAME (Type or Print)

SOLE PROPRIETOR – ENTER NAME AS SHOWN ON SSN (Last, First, M.I.)

E-MAIL ADDRESS

MAILING ADDRESS

BUSINESS ADDRESS

CITY, STATE, ZIP CODE

CITY, STATE, ZIP CODE

3

ENTER FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN):

		-							
--	--	---	--	--	--	--	--	--	--

PARTNERSHIP

CORPORATION:

MEDICAL (e.g., dentistry, psychotherapy, chiropractic, etc.)

LEGAL (e.g., attorney services)

EXEMPT (nonprofit)

ALL OTHERS

ESTATE OR TRUST

NOTE:
Payment will not be processed without an accompanying taxpayer I.D. number.

PAYEE ENTITY TYPE

CHECK ONE BOX ONLY

INDIVIDUAL OR SOLE PROPRIETOR
ENTER SOCIAL SECURITY NUMBER:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

(SSN required by authority of California Revenue and Tax Code Section 18646)

4

PAYEE RESIDENCY STATUS

California resident - Qualified to do business in California or maintains a permanent place of business in California.

California nonresident (see reverse side) - Payments to nonresidents for services may be subject to State income tax withholding.

No services performed in California.

Copy of Franchise Tax Board waiver of State withholding attached.

First, select one of these options



Scenario 1 – Payment to Agency

Contractor's Name will read "Agent's Name for the benefit of Agency Name"

Contractor's Name will read Agent's name and be signed by the Agent

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

AGREEMENT NUMBER 13-A- _____
REGISTRATION NUMBER _____

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
Joe Agent for the benefit of Insurance Benefits Company

2. The term of this Agreement is: From the Date Signed by the State below for one (1) year from said Date.

3. The maximum amount of this Agreement is: Undefined

4. 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	16 Pages
Exhibit E – Branding Guidelines	4 Pages
Exhibit F – Schedule of Commissions	1 Pages

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

CONTRACTOR	
CONTRACTOR'S NAME	Joe Agent
SIGNED BY (Typed Name)	Joe Agent NED(Do not type)
PRINTED NAME	Joe Agent, Sales Manager
ADDRESS	123 Any Street City, CA 12345

<i>California Department of General Services Use Only</i>



Scenario 1 – Payment to Agency

Contractor's Name will read "Agent's Name for the benefit of Company Name"

(Rev. September 2013)
California Health Benefit Exchange

Page 1 of 10

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 and the 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: _____

A. Purpose:



Scenario 2 – Payment to Agent

The SSN, the Sole Proprietor Name, and the mailing address will auto-populate

First, this select this option

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

1 INSTRUCTIONS: Complete all information on this form. Sign, date, and return to the State agency (at the bottom of this page). Prompt return of this **fully completed** form will prevent delays when processing this form will be used by State agencies to prepare Information Returns (1099). See reverse side for more information.
NOTE: Governmental entities, federal, State, and local (including school districts), are not required to complete this form.

2 PAYEE'S LEGAL BUSINESS NAME (Type or Print)

SOLE PROPRIETOR – ENTER NAME AS SHOWN ON SSN (Last, First, M.I.) **E-MAIL ADDRESS**

MAILING ADDRESS **BUSINESS ADDRESS**

CITY, STATE, ZIP CODE **CITY, STATE, ZIP CODE**

3 PAYEE ENTITY TYPE

ENTER FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN): [] - [] [] [] [] [] [] [] [] [] []

PARTNERSHIP ESTATE OR TRUST

CORPORATION:

MEDICAL (e.g., dentistry, psychotherapy, chiropractic, etc.)
 LEGAL (e.g., attorney services)
 EXEMPT (nonprofit)
 ALL OTHERS

NOTE: Payment will not be processed without an accompanying taxpayer I.D. number.

CHECK ONE BOX ONLY

INDIVIDUAL OR SOLE PROPRIETOR
ENTER SOCIAL SECURITY NUMBER: [] [] [] - [] [] [] - [] [] [] [] [] [] [] [] [] []
(SSN required by authority of California Revenue and Tax Code Section 18646)

4 PAYEE RESIDENCY STATUS

California resident - Qualified to do business in California or maintains a permanent place of business in California.
 California nonresident (see reverse side) - Payments to nonresidents for services may be subject to State income tax withholding.
 No services performed in California.
 Copy of Franchise Tax Board waiver of State withholding attached.



Scenario 2 – Payment to Agent

Contractor's Name will read "Agent's Name"

Contractor's Name will read Agent's name and be signed by the Agent

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

AGREEMENT NUMBER 13-A- _____
REGISTRATION NUMBER

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
Joe Agent

2. The term of this Agreement is: From the Date Signed by the State below for one (1) year from said Date.

3. The maximum amount of this Agreement is: Undefined

4. 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.

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Exhibit D – Business Associates Agreement	16 Pages
Exhibit E – Branding Guidelines	4 Pages
Exhibit F – Schedule of Commissions	1 Pages

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

CONTRACTOR	
CONTRACTOR'S NAME	Joe Agent
SIGNATURE	<i>Joe Agent</i> NED(Do not type)
PRINT NAME	Joe Agent, Sales Manager
ADDRESS	123 Any Street City, CA 12345

California Department of General Services Use Only



Scenario 2 – Payment to Agent

(Rev. September 2013)
California Health Benefit Exchange

Page 1 of 10

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 _____ an individual licensed by the California Department of Insurance to conduct 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: _____

A. Purpose:

Contractor's
Name will read
"Agent's Name"

Joe Agent



Help and Support

- **Should you need any additional support after reading the Instructions sent with the Agent Agreement Package, please contact the Agent Service Center at 877-453-9198 to answer any questions you may have.**



Conclusion – Questions?



www.CoveredCA.com

