Attachment D
Producer Appointment Application

By completing this Producer Appointment Application, the undersigned is applying to be a non-exclusive Producer to Molina Healthcare, Inc., on behalf of itself and its wholly-owned health plans identified on the signature authorization page of this Agreement for purposes of marketing the Company Products listed in Attachment B, Company Products.

Please Print Clearly

Name:	Alias/Other Names:
Birth Date:	Social Security #:
Tax ID:	National Producer Number (NPN):
Corporation Name:	Appointment Type: _____ Individual _____ Corporation
Mailing Preference: _____Home _____Business	
Home Address:	Business Address:
Home Phone:	Business Phone:
Fax Number:	Email (required):
Resident License State and License Number (attach copies of all licenses for appointment):	Non-Resident License States:
National Producer Number (NPN):	Marketplace ID Number:
Errors and Omissions coverage: Yes No Coverage Amount:	If Yes, name of carrier:

<u>Background – Please provide a complete explanation of any "yes" answers on a separate sheet</u>:

Yes	No	1. Have you ever had your insurance or securities license suspended, revoked or subject to disciplinary action, or have you ever had an application for an insurance license denied by any insurance department?
Yes	No	2. Have you ever been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?
Yes	No	3. Have you ever pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?
Yes	No	4. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?

Yes	No	5. Have you ever had a complaint filed against you with an insurance department, NASD or other regulatory agency or do you anticipate one being filed?
Yes	No	6. Have you been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?
Yes	No	7. Do you owe an insurance company or other person for any premiums collected or monies advanced?
Yes	No	8. Has any company or other person alleged that it has not received premiums or other monies due such company or person from you?
Yes	No	9. Do you agree to comply with all laws in the State you are appointed to sell in regards to marketing activities?
Yes	No	10. Do you agree to use ONLY marketing collaterals and advertisements that have been approved by Molina Healthcare, Inc. in connection with marketing Molina Healthcare, Inc. company products?
Yes	No	11. Do you agree to refrain from engaging in misleading, confusing, or "high pressure" sales tactics?

Attestation and Agreement

By signing below, I attest I have thoroughly reviewed this Producer Appointment Application and have answered all questions to the best of my knowledge.

I acknowledge that by signing and submitting this Producer Appointment Application, I have agreed to comply with all of the terms and conditions of Molina Healthcare, Inc.'s standard Producer Agreement. A copy of the Producer Agreement will be provided to me upon Molina Healthcare, Inc.'s approval of this Producer Appointment Application.

I acknowledge that upon approval of this Producer Appointment Application, I will be an independent contractor, not an employee of Molina Healthcare, Inc. Accordingly, I will have no claim for vacation or sick leave, retirement benefits, Social Security, Workers' Compensation benefits, disability or unemployment insurance benefits, or employee benefits of any kind.

I agree that I will not solicit individuals to enroll in Company Products until I receive notification from Molina Healthcare, Inc. that this Producer Appointment Application has been approved.

Applicant Signature: ____ Date: _______________

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS
(*All states except California, Minnesota and Oklahoma)*

This Disclosure and Authorization is provided to you in connection with your application (Producer Appointment Application) to Molina Healthcare, Inc. (the "Company") for status as a non-exclusive Producer to market the Company's Products listed in Attachment B, Company Products.

The Company desires to procure a consumer or investigative consumer report (or both) ("Background Reports") regarding your background for use by the Company or any legal affiliate (sister company or parent-subsidiary relationship) in evaluating your application for status as a non-exclusive Producer. Any Background Reports requested pursuant to your Authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency ("CRA") that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to the Company. To obtain contact information regarding CRA or to submit a written request for more information, contact: Molina Healthcare, Inc., Attention: Legal Department, 200 Oceangate, Suite 100, Long Beach, CA 90802.

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act."

AUTHORIZATION: I have submitted an Agent Appointment Application to the Company. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to the Company and its affiliates for the purpose of evaluating my application for status as a non-exclusive agent. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to SterlingBackcheck, Inc. retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law. I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and the Company will, in that event, forward such revocation promptly to SterlingBackcheck, Inc. that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) written revocation as described above, or (ii) twelve (12) months following the date of my signature below. A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

____

(Print Full Name and Residence Address)

____ _______________________

(Signature) *(Date)*

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS (*California*)

This Disclosure and Authorization is provided to you in connection with your application (Producer Appointment Application) to Molina Healthcare, Inc. (the "Company") for status as a non-exclusive Producer to market the Company's Products listed in Attachment B, Company Products.

The Company desires to procure a consumer or investigative consumer report (or both) ("Background Reports") regarding your background for use by the Company or any legal affiliate (sister company or parent-subsidiary relationship) in evaluating your application for status as a non-exclusive Producer. Background Reports will be obtained through SterlingBackcheck. Any Background Reports requested pursuant to your Authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may request more information about the nature and scope of Background Reports produced by any consumer reporting agency ("CRA") by submitting a written request to Company. You should submit any such written request for more information to Molina Healthcare, Inc., Attention: Legal Department, 200 Oceangate, Suite 100, Long Beach, CA 90802.

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act." You will be provided with a copy of any Background Report procured by Company if you check the box below.

________ By placing my initials on the line provided, I request a copy of any Background Report from any CRA retained by Company, at no extra charge.

Under section 1786.22 of the California Civil Code, you may view the file maintained on you by the CRA listed above. You may also obtain a copy of this file, upon submitting proper identification and paying the costs of duplication services, by appearing at the CRA in person or by mail; you may also receive a summary of the file by telephone. SterlingBackcheck is required to have personnel available to explain your file to you and SterlingBackcheck must explain to you any coded information appearing in your file. If you appear in person, you may be accompanied by one other person of your choosing, provided that person furnishes proper identification.

AUTHORIZATION: I have submitted an Agent Appointment Application to the Company. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to the Company and its affiliates for the purpose of evaluating my application for status as a non-exclusive agent. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to SterlingBackcheck retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law. I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to SterlingBackcheck that either prepared or is preparing Background Reports under this Disclosure and Authorization. In no event, however, will this authorization remain in effect beyond twelve (12) months following the date of my signature below. A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

____

(Print Full Name and Residence Address)

____ ____________________

(Signature) *(Date)*