Health Insurance Innovations

HEALTH INSURANCE INNOVATIONS
LICENSING CHECK LIST

Please complete the required forms listed below to sell the HII Plans.

1. **Complete and sign the HII Agent Information and Statement of Understanding Form**
2. **Sign the Commission Addendum (Include the name of your GA or MGA, if any)**
3. **Complete and sign the Agent Profile Form**
   (To sell the HII Plans)
4. **Complete and sign the Commission Direct Deposit Agreement, and include a copy of a voided check**
5. **Complete and sign the IRS W-9 Form**
6. **Attach a copy of your Errors & Omissions Insurance**
7. **Include current copies of your insurance agent license(s) for each state you plan to sell the HII plans.** *(Resident and Non-Resident and include any agency licenses)*

Submitted By:_____ Date:_____
(Please Print)

Recruited By:**Keith Clark- National Brokerage Group Inc. #E542000000**

Please call 1-877-376-5831 if you have any questions about the licensing process.

Mail or fax your completed forms and attachments to your GA / MGA or you can send them to Health Insurance Innovations via fax, email or mail.

Toll Free Fax: 1-877-376-5832
Email: lora@hiiquote.com
Health Insurance Innovations, LLC
218 E Bearss Ave., Suite 325
Tampa, FL 33613

Health Insurance Innovations
Agent Commission Addendum

	First Year	Renewal Years
Health Essential:	**28%**	**8%**
Med Plus STM	**18%**	**NA**

The Agent commission listed above is payable based on issued collected premiums, minus administration fees, enrollment fee, association dues or refunds; and for applications received and issued after the effective date of this Agent Commission Addendum.

Agent Signature: _____ Title:_____ Date:_____

Health Insurance Innovations

By: _____ Title: _____ Date: _____

Complete the following information:
Print Name:_____

E-Mail:_____ Company Name:_____

Address:_____ City: _____ St:_____ Zip: _____

GA Name: _____ Agent Code: _____ Email:_____

SGA Name: _____ Agent Code: _____ Email:_____

MGA Name: _____ Agent Code: _____ Email:_____

Recruited By: **Keith Clark- National Brokerage Group Inc. #E542000000**

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218 E Bearss Ave., Suite 325
Tampa, FL 33613

HEALTH INSURANCE INNOVATIONS (HII)
AGENT INFORMATION FORM

COMPLETE THE FOLLOWING INFORMATION ABOUT YOURSELF:

Agent Name _____ Date of Birth _____ Social Security# _____

Corporation/Agency Name _____ Tax I.D.*_____ Email _____

Business Street Address _____ City _____ St. _____ Zip _____

Resident Street Address _____ City _____ St. _____ Zip _____

Business Telephone # (_____) _____ Fax # (_____) _____ Resident Telephone # (_____) _____

** If we are to pay Marketing Fees/ Commissions to an Agency or Corporation, and you are not the Owner / Officer, we need the assignment below signed by you and we must have another License Request Form completed by the Agency Owner / Officer; and copies of their license. Include the Agency's license if applicable in your state.*

ANSWER THE FOLLOWING QUESTIONS:

1. Have you ever been convicted of a felony? ..... ❑ YES ❑ NO
2. Have you ever been involved in an investigation with any State Insurance Department? ..... ❑ YES ❑ NO
3. Has your license ever been suspended, cancelled or revoked by any State Insurance Department? ..... ❑ YES ❑ NO
4. Have you ever filed Bankruptcy, been sued or had a judgment entered against you? ..... ❑ YES ❑ NO

Any "YES" answer above requires a separate statement, including dates, location, basis of charge and legal documentation indicating disposition of case.

1. Do you carry errors and omissions coverage? ❑ YES ❑ NO (If YES, list carrier name and limits)_____
2. What lines of insurance are you licensed to sell for: ❑ Life ❑ Accident / Health ❑ Other _____
3. Please list the states where you hold a license: State _____ License #_____; State _____ License # _____; State _____ License #_____;
   Attach copies of your resident and all nonresident licenses. *(We do not need an appointment fee.)*

ASSIGNMENT OF MARKETING FEES / COMMISSIONS REQUEST:

Only complete the following if you want HII to pay your Marketing Fees/ Commissions to a Corp., Agency or another Agent.

I_____ Code #: _____ hereby assign to Assignee:_____ all of my right, title, and interest in Marketing Fees and/or renewals to which I am now entitled or become entitled, under existing contracts and agreements, heretofore entered into by and between myself and HII I hereby authorize and empower HII, to pay assignee all Marketing Fees and renewals now due or which may accrue under said contracts, for a period of one year from this date and thereafter until such time a s I terminate this assignment by written notice to HII. I agree that such payments of Marketing Fees under my contract are the same as if payment was made directly to me. I hereby covenant and agree that I am the absolute and sole owner of said Marketing Fees, free from prior assignment or any encumbrance of any kind or character whatsoever, and that I have full right and lawful authority to sell and transfer the same as aforesaid.

Witness my hand this _____ day of_____, Year_____, Agent's Signature_____

CAUTION: The person assigning his or her Marketing Fees (assignor) will not recover the right to receive any further Marketing Fees during the one year period from the date of this assignment unless and until the person to whom such rights are assigned (assignee) releases, in writing, his or her rights to receive such Marketing Fees. Please be certain you understand this before signing the form. This instrument may be revoked, in writing, by the Assignor at any time after the one year period.

Address of Assignee: _____ Tax I.D.#: _____

STATEMENT OF UNDERSTANDING FORM:

This Statement of Understanding must be signed to be in effect, and is between undersigned Agent and Health Insurance Innovations, herein referred to HII. HII agrees to pay Marketing Fees / Commissions on the plans listed on the attached Addendum accordance with and subject to the conditions and covenants below.

- The term "monthly plan cost and paid" shall mean monies, excluding any enrollment fee, monthly administrative fee or association dues, due and paid for the plan after the effective date of this Agreement by each member and for whom the Agent is the representative of record.
- Marketing Fees / Commissions shall be payable only when Agent is (a) properly approved to transact business for HII and (b) is continuously recognized by HII as the Agent of record to receive said Marketing Fees / Commissions.
- This Agreement may be terminated by either party with a 30 days written notice but only with respect to new cases. Such terminations will have no effect on the payment of Marketing Fees / Commissions on business written prior to the effective date of termination as may otherwise be payable.
- No advertising material (on paper, over the radio or television or on the Internet) bearing HII or our product name or describing any named product distributed by HII can be produced without prior written approval from HII.
- The Agent is an independent contractor, not an employee of HII
- The Agent has no authority to act on behalf of HII, bind coverage, waive or alter any provision of the application or the Product under which membership is issued.
- Representations and opinions of the Agent are not binding on HII plans.
- By signing below I am giving HII prior written express invitation and permission to transmit facsimile and email advertisements to me.

READ CAREFULLY BEFORE SIGNING:

The above information is true and complete. I understand false statements on this form may be sufficient cause for termination. I have read the Statement of Understanding and understand that if these guidelines are not followed, the result will be termination of this Agreement.

Agent Signature:_____ Date:_____ Title:_____

GA Name:_____ HII Code #:_____ MGA Name: _____ HII Code #:_____

Recruited By:**Keith Clark- National Brokerage Group Inc. #E542000000**

Mail your completed required forms and a copy of your current license(s) to your GA or MGA.

Toll Free Fax: 1-877-376-5832
Email: lora@hiiquote.com
Health Insurance Innovations, LLC
218 E Bearss Ave., Suite 325

HEALTH INSURANCE INNOVATIONS

Agent Profile Form

Last Name	*First Name*	*Middle*

Social Security Number	*Date of Birth*
Agency Name	*Tax ID#*

Resident Address	*City*	*State*	*Zip*
Business Address	*City*	*State*	*Zip*

Business Phone	*Cell Phone*	*Fax Number*

Email	*Website*

Preferred Mailing Address	☐	*Business*	☐	*Resident*

Please check off the states below, in which you will be representing HII. Please provide a copy of insurance license(s) for each state checked.

If assigning commissions to an agency or corporation, please also provide a copy of the agency license (if applicable).

☐	AL	☐	AK	☐	AZ	☐	AR	☐	CA	☐	CO	☐	CT	☐	DE
☐	DC	☐	FL	☐	GA	☐	HI	☐	ID	☐	IL	☐	IN	☐	IA
☐	KS	☐	KY	☐	LA	☐	ME	☐	MD	☐	MA	☐	MI	☐	MN
☐	MS	☐	MO	☐	MT	☐	NE	☐	NV	☐	NH	☐	NJ	☐	NM
☐	NY	☐	NC	☐	ND	☐	OH	☐	OK	☐	OR	☐	PA	☐	RI
☐	SC	☐	SD	☐	TN	☐	TX	☐	UT	☐	VT	☐	VA	☐	WA
☐	WV	☐	WI	☐	WY										

Notice Regarding Background Checks

*Before our company may begin processing your appointment and/or license application, we are required by *federal law to ensure that all agents and/or employees we wish to do business with are not convicted criminals or felons. *(Criminal checks are based on the Violent Crime Control Act of 1994)*

We will notify you if your background report results are unfavorable and we consequently decline your license appointment. In addition, you will be advised to discontinue submission of business to our company and/or service to any of our clients as well. In the event that the information reflected in the criminal report is incorrect, we will advise you of the protocol to appeal.

For Office Use Only					
☐					
Appointment requested for	☐	Accident and Health	☐	Property and Casualty	
Appointing Company					
Comments					

Toll Free Fax: 1-877-376-5832
Email: lora@hiiquote.com
Health Insurance Innovations, LLC
218 E Bearss Ave., Suite 325

P&C PRODUCER APPOINTMENT FORM
APPOINTMENT SECTION

DATE (MM/DD/YYYY)

PROVIDE ALL INFORMATION KNOWN AT THE TIME THE FORM IS COMPLETED

CARRIER	NAIC CODE
Starr Indemnity & Liability Company	38318

AGENCY INFORMATION

NAME AND ADDRESS	FEIN:
	LICENSING CONTACT:
	CONTACT PHONE (A/C, No, Ext):
	CONTACT FAX (A/C, No):
	CONTACT E-MAIL:

PRODUCER INFORMATION

FULL LEGAL NAME	PREFIX	FIRST NAME	MIDDLE NAME	SURNAME	SUFFIX

POSITION / TITLE IN AGENCY	BIRTH DATE (MM/DD/YYYY)	NATIONAL PRODUCER #	SOCIAL SECURITY #

RESIDENCE ADDRESS (Including County)	BUSINESS PHONE (AC, No, Ext):
	BUSINESS E-MAIL ADDRESS

OTHER NAMES USED

PREFIX	FIRST NAME	MIDDLE NAME	SURNAME	SUFFIX	NAME TYPE (Check One) ALIAS	MAIDEN	PREVIOUS
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐

STATES AND US TERRITORIES (Check all that apply)

☐ ALL STATES

☐ AK ALASKA	☐ KY KENTUCKY	☐ NY NEW YORK
☐ AL ALABAMA	☐ LA LOUISIANA	☐ OH OHIO
☐ AR ARKANSAS	☐ MA MASSACHUSETTS	☐ OK OKLAHOMA
☐ AZ ARIZONA	☐ MD MARYLAND	☐ OR OREGON
☐ CA CALIFORNIA	☐ ME MAINE	☐ PA PENNSYLVANIA
☐ CO COLORADO	☐ MI MICHIGAN	☐ RI RHODE ISLAND
☐ CT CONNECTICUT	☐ MN MINNESOTA	☐ SC SOUTH CAROLINA
☐ DC DISTRICT OF COLUMBIA	☐ MO MISSOURI	☐ SD SOUTH DAKOTA
☐ DE DELAWARE	☐ MS MISSISSIPPI	☐ TN TENNESSEE
☐ FL FLORIDA	☐ MT MONTANA	☐ TX TEXAS
☐ GA GEORGIA	☐ NC NORTH CAROLINA	☐ UT UTAH
☐ HI HAWAII	☐ ND NORTH DAKOTA	☐ VA VIRGINIA
☐ IA IOWA	☐ NE NEBRASKA	☐ VT VERMONT
☐ ID IDAHO	☐ NH NEW HAMPSHIRE	☐ WA WASHINGTON
☐ IL ILLINOIS	☐ NJ NEW JERSEY	☐ WI WISCONSIN
☐ IN INDIANA	☐ NM NEW MEXICO	☐ WV WEST VIRGINIA
☐ KS KANSAS	☐ NV NEVADA	☐ WY WYOMING

☐ ALL TERRITORIES

- ☐ AS AMERICAN SAMOA
- ☐ GU GUAM
- ☐ PR PUERTO RICO
- ☐ VI VIRGIN ISLANDS

P&C PRODUCER APPOINTMENT FORM
BACKGROUND QUESTIONS

DATE (MM/DD/YYYY)

PROVIDE ALL INFORMATION KNOWN AT THE TIME THE FORM IS COMPLETED

COMPLETE ONLY FOR THOSE INSURERS REQUIRING THIS INFORMATION

CARRIER	NAIC CODE
Starr Indemnity & Liability Company	38318

BACKGROUND QUESTIONS

EXPLAIN ALL "YES" RESPONSES. PROVIDE COMPLETE DETAILS AND ATTACH APPROPRIATE DOCUMENTS (e.g., Official Court Records).	Y/N
1. HAVE YOU FILED FOR, OR BEEN DISCHARGED FROM ANY BANKRUPTCY (INCLUDING PERSONAL BANKRUPTCY), INSOLVENCY OR ASSIGNMENT FOR THE BENEFIT OF CREDITORS WITH A FILING OR DISCHARGE DATE, WHICHEVER IS LATER, IN THE LAST FIVE (5) YEARS?	☐
2. DO YOU HAVE DELINQUENT UNPAID DEBTS EXCEEDING, IN TOTAL, $10,000? (ADD TOGETHER DELINQUENT: CONSUMER DEBT, TAX LIENS, LOANS, CHILD SUPPORT PAYMENTS, ALIMONY PAYMENTS, CIVIL JUDGMENTS, AND OTHER DELINQUENT DEBT.)	☐
3. WITH THE EXCEPTION OF SITUATIONS SPECIFIC TO CONTINUING EDUCATION, HAVE YOU EVER BEEN THE SUBJECT OF AN ADMINISTRATIVE PROCEEDING REGARDING ANY PROFESSIONAL OR OCCUPATIONAL LICENSE THAT RESULTED IN DISCIPLINARY ACTION?	☐
4. WITH THE EXCEPTION OF SITUATIONS SPECIFIC TO CONTINUING EDUCATION, HAS YOUR INSURANCE LICENSE EVER BEEN SUSPENDED BY, SUBJECT TO A CONSENT ORDER FROM, REVOKED BY, OR SURRENDERED TO, ANY REGULATORY AGENCY, OR HAVE YOU EVER BEEN FINED, PENALIZED, SANCTIONED OR SUBJECT TO ANY OTHER DISCIPLINARY ACTION BY A STATE OR FEDERAL REGULATORY AGENCY OR SELF REGULATORY ORGANIZATION OR ARE YOU CURRENTLY UNDER INVESTIGATION AS A RESULT OF YOUR ACTIVITIES IN THE BUSINESS OF INSURANCE, SECURITIES, BANKING, INVESTMENT BANKING OR REAL ESTATE?	☐
5. HAVE YOU EVER HAD AN INSURANCE AGENCY CONTRACT OR ANY OTHER BUSINESS RELATIONSHIP WITH AN INSURANCE COMPANY TERMINATED FOR ANY ALLEGED MISCONDUCT?	☐
6. HAVE YOU EVER BEEN CONVICTED OF, PLEAD GUILTY OR NO CONTEST TO, OR ARE YOU CURRENTLY CHARGED WITH OR UNDER INVESTIGATION FOR ANY MISDEMEANOR INVOLVING DISHONESTY OR BREACH OF TRUST OR ANY FELONY?	☐
7. ARE YOU NOW THE SUBJECT OF ANY COMPLAINT, INVESTIGATION, OR PROCEEDING THAT COULD RESULT IN A "YES" ANSWER TO ANY OF THE PREVIOUS QUESTIONS?	☐

REMARKS

I HEREBY CERTIFY THAT ALL OF THE INFORMATION HEREIN IS ACCURATE AND COMPLETE. I ACKNOWLEDGE AND AGREE THAT MY APPOINTMENT WILL, IN PART, BE BASED ON THIS PRODUCER APPOINTMENT FORM AND BACKGROUND INFORMATION, AND ANY FALSIFICATION, MISREPRESENTATION OR OMISSION OF INFORMATION FROM THIS FORM MAY RESULT IN THE WITHHOLDING OR WITHDRAWAL OF ANY OFFER OF APPOINTMENT OR THE REVOCATION OF APPOINTMENT BY THE COMPANY WHENEVER DISCOVERED.

PRINT NAME	
SIGNATURE	DATE (MM/DD/YYYY)

ATTACH TO ACORD 817

NOTICE OF BACKGROUND CHECK AND FAIR CREDIT REPORTING ACT DISCLOSURE

This notice is being provided to you by the Company pursuant to the Fair Credit Reporting Act ("FCRA"). As used herein, "the Company" means the identified insurer (the insurer identified on this form) and its subsidiaries, affiliates, officers, employees, agents and representatives.

In connection with determining your eligibility for an insurance agent or producer license and/or your eligibility to be appointed or sponsored as an agent of the Company, and to maintain such license and appointment, in one or more states, the Company will from time to time conduct background checks. Such background checks may include the ordering of "consumer reports" from a "consumer reporting agency" containing information on your criminal and credit history. These terms are defined in the FCRA.

I acknowledge and agree that this Producer Appointment Form does not constitute a contract of any kind. I hereby authorize the Company and its authorized agents to investigate my background, references, character, past employment, education, criminal or police reports, including those mandated by both public and private organizations and all public records for the purpose of confirming the information contained on this application and/or obtaining other information which may be material to my qualifications for my appointment. I hereby consent to the Company obtaining such information from time to time, as the Company, in its sole discretion, deems necessary. I further consent to the disclosure of the Producer Appointment Form and background information to government or regulatory agencies.

I hereby release the Company, its authorized agents and any person or entity which provides information pursuant to this authorization, from any and all liabilities, claims or lawsuits relating to the information obtained from any and all of the above referenced sources, or from the furnishing of the same. This is a continuing authorization.

I understand that I am obligated to immediately report any event that changes any of the information, in any manner, which I have provided on this application.

I hereby certify that all of the information herein is accurate and complete. Finally, I acknowledge and agree that my appointment will, in part, be based on this Producer Appointment Form and background information, and any falsification, misrepresentation or omission of information from this form may result in the withholding or withdrawal of any offer of appointment or the revocation of appointment by the Company whenever discovered.

For Maine Applicants Only

Upon request, you will be informed whether or not an investigative consumer report was requested, and if such a report was requested, the name and address of the consumer reporting agency furnishing the report. You may request and receive from us, within 5 business days of our receipt of your request, the name, address and telephone number of the nearest unit designated to handle inquiries for the consumer reporting agency issuing an investigative consumer report concerning you. You also have the right, under Maine law, to request and promptly receive from all such agencies copies of any reports.

For New York Applicants Only

You have the right, upon written request, to be informed of whether or not a consumer report was requested. If a consumer report is requested, you will be provided with the name and address of the consumer reporting agency furnishing the report.

For Washington Applicants Only

If we request an investigative consumer report, you have the right, upon written request made within a reasonable period of time, to receive from us a complete and accurate disclosure of the nature and scope of the investigation. You have the right to request from the consumer reporting agency a summary of your rights and remedies under state law.

For California*, Minnesota, and Oklahoma Applicants Only

A consumer credit report will be obtained through:

Company Name	Street Address	
City	State	Zip Code

If a **consumer credit report** is obtained, I understand that I am entitled to receive a copy. I have indicated below whether I would like a copy.

YES _____ Initials NO _____ Initials

If an **investigative consumer report** and/or consumer report is processed, I understand that I am entitled to receive a copy. I have indicated below whether I would like a copy.

YES _____ Initials NO _____ Initials

*** California Applicants**: If you chose to receive a copy of the consumer report, it will be sent within three (3) days of the employer receiving a copy of the consumer report and you will receive a copy of the investigative consumer report within seven (7) days of the employer's receipt of the report (unless you elected not to get a copy of the report).

PRINT NAME	
SIGNATURE	DATE (MM/DD/YYYY)

Health Insurance Innovations
218 E. Bearss Ave., Suite 325
Tampa, FL 33613
Phone: 1-877-376-5831
Fax: 1-877-376-5832

Commission Automatic Direct Deposit & Agent Authorization Agreement Form

*Producer Name: _____ or Company Name: _____

*Producer SSN: _____ or Company FEIN:_____

Producer E-mail Address:_____ For notification of funds availability)

***Note:** All Commission earnings are reported to the IRS under the FEIN (or SSN) of the license holder *(as allowed under State licensing regulations)*. Please sign below in acknowledgement.

Producer Signature: _____Date: _____

I (we) hereby authorize **Health Insurance Innovations, LLC** through **Fox Chase Bank,** to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries made in error to my (our) account listed below. I (we) also authorize my (our) depository named below, to debit and/or credit the same to such account.
I can cancel or authorize a change to the bank information for this automatic deposit at any time by calling or writing to Health Insurance Innovations, LLC or its authorized agent. I agree that Health Insurance Innovations, LLC or my Financial Institution can cancel automatic deposits for any reason at any time. I have a copy of this agreement and I know I can also contact Health Insurance Innovations, LLC or its agent for a copy.

Authorized Name on Account (Print):_____

Bank/Credit Union Information: ***(Attach a voided check or savings account slip)***

Bank Name:_____ Branch Location:_____

Indicate one: _____ Checking Account _____ Savings Account

Routing /ABA Number (Must be 9 digits) :_____

Account Number:_____

Authorized Account Signature on Account:_____

ATTACH VOIDED CHECK HERE

MGA Name: _____ HII Code #: _____

HII-EFT-Form 10/09

Form **W-9**
(Rev. October 2007)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership
☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶
☐ Other (see instructions) ▶

☐ Exempt payee

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

or

Employer identification number

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. 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
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here **Signature of U.S. person ▶** **Date ▶**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,