



Agent Appointment Kit Checklist and Fax Cover Sheet

ATTN: OptiCare Enrollment Department

Fax Number: (252) 451-2148

From: _____

Contact Number: _____

Thank you for working with OptiCare Vision Plans! Please allow this page to serve as a checklist in ensuring that we have all of the necessary information to process your kit timely and accurately.

The following pages may be faxed to our Enrollment Department for processing. **However, and original signature is required** and should be mailed to the address at the bottom of the Agent Data Sheet.

Should you have any questions as you are completing the following documents, please contact our Enrollment Department at (252) 451-2288.

Have you completed everything?

- Completed and Executed Agent Data Sheet
- Copy of Home State Health Insurance Agent License
- Copy of Foreign State Health Insurance Agent License (if applicable)
- Copy of Health Insurance Agent Errors & Omissions Policy Face Sheet (Kansas Only)
- Completed Business Associate Agreement
- Complete W-9 Form

*****Please Note*****

*Incomplete Agent Appointment Kits will cause delays in processing.
Enrollment is an agent responsibility.*



OMISSION OF ANY INFORMATION WILL RESULT IN A DELAY OF APPOINTMENT AND PAYING OF COMMISSION

NOTE: No person is permitted to solicit, sell or procure an application for insurance until he has in his possession an insurance agent's license authorizing him to solicit, sell or procure applications for Fidelity Security Life Insurance Company.

A. IDENTIFICATION: (Please print in ink or type - **Do Not Abbreviate**)

Name (Last, First, Middle)				Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Social Security Number	Date of Birth	Place of Birth	Tax I.D. No.		Age
Firm Name (Agency Name if applicable)					Send Mail to:
Business Address				Telephone & Fax #	
Street	City	State	County	Zip	()
Resident Address				Telephone & Fax #	
Street	City	State	County	Zip	()
Currently Licensed By State Of:		License No.	Issued To:		
(attach a copy of home state license)			<input type="checkbox"/> Ind.	<input type="checkbox"/> Corp.	<input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietor
What type of product(s) do you plan to sell for FSL?		<input type="checkbox"/> Life	<input type="checkbox"/> Health/Accident	<input type="checkbox"/> Fixed Annuity	

B. BACKGROUND - Use separate page if neededIF YES TO ANY OF QUESTIONS 1-9, PLEASE ATTACH DETAILS AND DATES.

- | | Yes | No | Month/Year |
|---|--------------------------|--------------------------|------------|
| 1. Have you ever had ownership interest in a business venture which declared bankruptcy?
(If Yes, give month and year.) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 2. Have you been a Judgment Debtor or ever declared personal bankruptcy? (If Yes, give month and year.) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 3. Are you in good standing and full compliance with respect to state taxes or child support?
(If no, give details.) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 4. Have you ever had a bond declined or cancelled? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 5. Have you ever been convicted for any offense other than a minor traffic violation? Your failure to disclose a felony conviction will result in an automatic denial. | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 6. Have you ever been cited, fined, suspended, revoked or refused a license by any state?
(If Yes, give state, month and year.) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 7. Have you ever been short in accounts with any employer? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 8. Do you owe an unpaid balance to any insurance company? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 9. Are you now employed by, or associated with to any degree, directly or indirectly, a bank, savings and loan or other financial institution? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 10. For Agents applying to sell cash value life insurance and/or annuities :
Have you completed Anti-Money Laundering training ? | <input type="checkbox"/> | <input type="checkbox"/> | N/A |
| 11. Please provide the carrier for your Errors & Omissions coverage, the policy number and the name of the insured. | | | _____ |

12. List past and current companies you represent or have represented in the last 5 years.

From	To	Name	Street Address, City, State, Zip	Telephone No.
				()
				()

C. CERTIFICATION / AUTHORIZATION

13. a. I certify that I have answered all questions honestly and to the best of my knowledge.
 b. I also authorize Fidelity Security Life Insurance Company to order an investigative report as may be required. I understand that information for the report may be secured from financial resources, and/or public records, or personal interviews with third parties, such as family members, business associates and/or others with whom I am acquainted.

This inquiry may include information as to my character, general reputation, personal characteristics, mode of living or educational background. I understand I have the right to make a written request within a reasonable period of time for a complete and accurate disclosure of this information if I so desire.

Date _____ Signature _____

Date _____ Appointing Premier General Agent _____

Owner or Partner
 Corporate Officer
 Representative (Agent)

Return to → **OptiCare Vision Plans**
 Agent Services, P.O.Box 7548
 112 Zebulon Court, Rocky Mount
 North Carolina, 27804

Agent # _____
 Date _____



P O Box 7548. Rocky Mount, North Carolina, 27804

Agent Services
OptiCare Vision Plans
P.O. Box 7548
Rocky Mount, NC 27804

Security Letter
Fax 252-451-2158

OptiCare Agent Services,

Please accept this letter as a request to set up an account to access the secure areas of the OptiCare Vision Plans Web site at www.opticarevisionplans.com. I understand this access is available to agents currently appointed with Fidelity Security Life Insurance Company via OptiCare Vision Plans.

I hereby attest that the information given in this letter of application is accurate and complete. By signing this document I fully understand and agree to the following terms and conditions:

- 1. It is my responsibility to ensure that the security code provided to me by OptiCare to gain access to confidential information maintained on OptiCare's Web site will be maintained in confidence and only used by me and/or by my employed staff.
2. In the event my security code is compromised in any way, I will immediately notify OptiCare's Agent Services Department to report such incident and to request a new security code.
3. I acknowledge that OptiCare's security access code can only be communicated in writing and sent by first-class mail to my designated primary office location.
4. My security access code to OptiCare's Web site may be terminated at any time without notice at the sole discretion of OptiCare.
5. Unauthorized use of my security code may be grounds for termination of appointment.
6. All information on this form will be verified and must match the information on the Agent Data Sheet.
7. Should any agent sharing the same tax ID number, or any staff member of my office, who accesses the OptiCare's Web site using a shared tax ID security code terminates employment, it is my responsibility to notify OptiCare's Agent Service's Division of said termination so that a new security code may be issued.
8. Should my appointment terminate, I acknowledge that my access to the Web site will be terminated the date my termination becomes effective.
9. I acknowledge that my licensing and demographic information will be available within the OptiCare secure site for changes, printing, and submission to OptiCare and, therefore, available to my staff members who are given access to the Web site. (If you do NOT want your licensing and demographic information displayed, please initial here. [_____]).

Signature: _____ Date Signed: _____

Full Name: _____

(Print)

Office Addr: _____

Tax ID No.: _____ -OR- SSN: _____

Office Ph. No.: _____ Office Fax No.: _____

Office Email: _____ (needed for system announcements)

Please ensure that all agents in your office (who share the same TIN) have signed and completed a form before returning this letter to the above address.

Table with 6 columns: Fidelity Agent #, AS Name, AS Date, Sec Setup, User ID, Password

BUSINESS ASSOCIATE AGREEMENT

This **BUSINESS ASSOCIATE AGREEMENT** (“*Agreement*”) is entered into on this _____ day of _____, 201_, by and between OptiCare Vision Company, Inc. (“*Covered Entity*”) and _____ (“*Business Associate*”).

WHEREAS, pursuant to an oral or written understanding or arrangement between Covered Entity and Business Associate (“*Services Arrangement*”), the parties intend for Business Associate to provide certain functions, activities, and/or services (collectively, “*Services*”) to Covered Entity;

WHEREAS, in connection with such Services, Covered Entity will make available and/or transfer to Business Associate, or Business Associate will create on behalf of Covered Entity, certain Protected Health Information (as such term is defined at 45 C.F.R. § 164.501) (“*PHI*”); and

WHEREAS, pursuant to the authorities set forth above, Business Associate may use or disclose PHI only in accordance with this Agreement.

NOW, THEREFORE, Covered Entity and Business Associate agree as follows:

1. **Definitions.** The Health Insurance Portability and Accountability Act of 1996 (“*HIPAA*”), the Health Information Technology for Economic and Clinical Health Act (“*HITECH*”), and the implementing regulations thereunder, including but not limited to the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164 (the “*Privacy Rule*”) and the Security Standards for the Protection of Electronic Health Information at 45 C.F.R. Parts 160 and 164 (the “*Security Rule*”), as may be amended from time to time, shall collectively be referred to herein as the “*HIPAA Authorities.*” All other capitalized terms hereunder shall have the meaning ascribed to them elsewhere in this Agreement, or, if no such definition is specified herein, shall have the meaning set forth in the HIPAA Authorities.

2. **Interpretation of Provisions of this Agreement.** In the event of an inconsistency between the provisions of this Agreement and the mandatory terms of the HIPAA Authorities, the terms of the HIPAA Authorities shall prevail. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with the HIPAA Authorities. A reference in this Agreement to a section in the HIPAA Authorities means the section in effect or as amended. Titles or headings are used in this Agreement for reference only and shall not have any effect on the interpretation of this Agreement.

3. **Obligations of Business Associate.**

3.1 **Description of Services Provided.** The parties agree that, pursuant to the Services Arrangement, if applicable, Covered Entity has retained or will be retaining Business Associate for the following purpose: furnishing sales for the OptiCare Employer Direct Product in which Covered Entity intends to disclose or provide access to certain PHI to Business Associate. The parties agree that nothing in this Section 3.1 shall be interpreted as superseding the terms of any Services Arrangement that may exist between the parties, if any.

3.2 **Limits on Use and Disclosure.** Business Associate agrees to not use or further disclose PHI other than as permitted or required by this Agreement or as required by law.

3.3 Safeguards. Business Associate agrees to use reasonable and appropriate administrative, physical and technical safeguards to prevent use or disclosure of PHI other than as provided for by this Agreement.

3.4 Mitigation of Harm. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement or the HIPAA Authorities.

3.5 Report of Improper Use or Disclosure. Business Associate agrees to notify Covered Entity, in writing or orally, without unreasonable delay, but in no case more than five (5) calendar days, of any incident involving the acquisition, access, use or disclosure of the PHI not provided for by this Agreement of which Business Associate becomes aware. As soon as reasonably possible thereafter, in no case more than fourteen (14) calendar days following the incident at issue, Business Associate shall provide Covered Entity with a written report which shall include but not be limited to: i) a description of the circumstances under which the incident occurred; ii) the date of the incident and the date that the incident was discovered; iii) a description of the types of PHI involved in the incident; iv) the identification of each Individual whose PHI is known or is reasonably believed by the Business Associate to have been affected; and v) any recommendations that the Business Associate may have, if any, regarding the steps that Individuals may take to protect themselves from harm.. To the extent that Covered Entity reasonably determines that such incident constitutes a Breach of Unsecured PHI by Business Associate that necessitates the notification of Individuals by Covered Entity under HITECH, Business Associate agrees that it shall immediately reimburse Covered Entity for the reasonable expenses of such notification process. Business Associate shall cooperate with any investigation of such incident conducted by Covered Entity in connection with any report made pursuant to this Section.

3.6 Agents and Subcontractors. Business Associate agrees to ensure that any agent or subcontractor to whom Business Associate provides PHI agrees in writing to the same restrictions and conditions that apply to Business Associate through this Agreement with respect to such PHI prior to the actual disclosure of PHI to such agents or subcontractors..

3.7 Access to Records. At the request of Covered Entity and within five (5) business days of such request and in a reasonable manner designated by Covered Entity, Business Associate shall provide access to PHI in a Designated Record Set to Covered Entity or, as directed by Covered Entity, to an Individual, in a manner compliance with 45 CFR §164.524 and/or other applicable provisions of the HIPAA Authorities.

3.8 Amendments to PHI. At the request of Covered Entity, or, as directed by Covered Entity, at the request of an Individual, Business Associate shall make, within five (5) business days of such request and in a reasonable manner designated by Covered Entity, any amendment(s) to PHI in a Designated Record Set to which the Covered Entity has agreed pursuant to 45 CFR §164.526, or shall otherwise assist Covered Entity in complying with Covered Entity's obligations under 45 CFR §164.526.

3.9 Availability of Internal Practices, Books and Records. Business Associate shall make its internal practices, books and records, including but not limited to policies and procedures relating to the use and disclosure of PHI, available to Covered Entity or the Secretary for purposes of determining Covered Entity's compliance with the HIPAA Authorities, in a time and manner designated by Covered Entity or the Secretary, as applicable.

3.10 Accounting of Disclosures. Business Associate shall document such disclosures of PHI and information related to such disclosures (i.e., (i) the date of the disclosure; (ii) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (iii) a brief description

of the PHI disclosed; and (iv) a brief statement of the purpose of the disclosure that reasonably states the basis for the disclosure) as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR §164.528. Such documentation shall be maintained with regard to all disclosures of PHI, except for those disclosures that are expressly exempted from the documentation requirement under the HIPAA Authorities (see, e.g., 45 CFR §§164.502; 164.508; 164.510; 164.512, etc.). Documentation required to be collected by the Business Associate under this Section shall be retained for a minimum of six (6) years, unless otherwise provided under the HIPAA Authorities. Business Associate shall further provide the information collected pursuant to this Section to Covered Entity or an Individual, within five (5) business days of the applicable request and in a reasonable manner designated by Covered Entity, as necessary to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR §164.528 or other applicable provision of the HIPAA Authorities.

3.11 Disclosure of Minimum PHI. Business Associate agrees that it shall request, use and/or disclose only the amount and content of PHI that is the Minimum Necessary for Business Associate to fulfill its obligations under the terms and conditions of this Agreement. Business Associate acknowledges that such Minimum Necessary standard shall apply with respect to uses and disclosures by and among members of Business Associate's workforce as well as by or to third parties as permitted hereunder.

3.12 Notification of Claims. Business Associate shall promptly notify Covered Entity upon notification or receipt of any civil or criminal claims, demands, causes of action, lawsuits, or governmental enforcement actions ("**Actions**") arising out of or related to this Agreement or PHI, or relating to Business Associate's conduct or status as a business associate for any covered entity, regardless of whether Covered Entity and/or Business Associate are named as parties to such Actions.

3.13 Security Rule Requirements. Business Associate shall implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Covered Entity as required by the Security Rule. Business Associate agrees to report to Covered Entity any use or disclosure of PHI not provided for by this Agreement or the HIPAA Authorities of which it becomes aware, including any Security Incident. Accordingly, Business Associate agrees to report any successful Security Incident of which it becomes aware to Covered Entity immediately, but not later than five (5) calendar days after the Security Incident, and agrees to provide a monthly aggregate report of all attempted Security Incidents (e.g., a request-response utility used to determine whether a specific Internet Protocol [IP] address, or host, exists or is accessible) of which it becomes aware to Covered Entity no later than the fifth day of each month following the month in which any such attempted Security Incidents occurred. In addition, Business Associate agrees to provide detailed information regarding any successful and/or attempted Security Incident(s) to Covered Entity upon request, within the capabilities of Business Associate. All reports provided by Business Associate pursuant to this Section 3.3 shall include the actions and the mitigation steps, if any, taken by Business Associate in response to the Security Incident(s).

3.14 HITECH Compliance. Requirements of HITECH or its implementing regulations that are made applicable with respect to business associates, or any other provision required to be included in this Agreement pursuant to HITECH or its implementing regulations, are incorporated into this Agreement by this reference.

4. Permitted Uses and Disclosures by Business Associate.

4.1 Use or Disclosure to Perform Functions, Activities, or Services. Except as otherwise limited in this Agreement, Business Associate may use or disclose PHI to perform those functions,

activities, or services that Business Associate performs for, or on behalf of, Covered Entity as specified in the Services Arrangement, or as set forth in Section 3.1 if no Services Arrangement exists between the parties, provided that such use or disclosure would not violate the Privacy Rule, or the policies and procedures of Covered Entity relating to the “Minimum Necessary Standard,” if done by Covered Entity. Any such use or disclosure shall be limited to those reasons and those Individuals as necessary to meet the Business Associate’s obligations under the Services Arrangement or Section 3.1 hereof, as applicable.

4.2 Appropriate Uses of PHI. Except as may be otherwise limited in this Agreement, Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

4.3 Confidentiality Assurances and Notification. Except as may be otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration of the Business Associate, provided that disclosures are Required by Law, or Business Associate obtains reasonable assurances from the person to whom the PHI is disclosed that such PHI will remain confidential and used or further disclosed only as Required by Law or for the purpose for which such PHI was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the PHI has been breached.

4.4 Data Aggregation Services. As applicable, Business Associate may use PHI to provide Data Aggregation services to Covered Entity as permitted by 42 CFR § 164.504(e)(2)(i)(B), except as may be otherwise provided by this Agreement.

5. Indemnification. Business Associate shall indemnify and hold harmless Covered Entity against, and reimburse Covered Entity for, any expense, loss, damages, fees, costs, claims or liabilities of any kind arising out of or related to any Actions, whether asserted or threatened, or whether instigated by a third party or by Business Associate, arising out of or related to Business Associate’s acts and omissions associated with Business Associate’s obligations under this Agreement or its use or disclosure of PHI or the use and disclosure of PHI by an agent or subcontractor of Business Associate. Such indemnification shall include, but not be limited to, the payment of all reasonable attorney fees associated with any such Action. Business Associate shall obtain and maintain at its sole expense, and in amounts consistent with industry standards, insurance to support its indemnification obligations hereunder. Business Associate shall provide a certificate of insurance evidencing such coverage to Covered Entity upon request.

6. Obligations of Covered Entity.

6.1 Notice of Privacy Practices. Covered Entity shall notify Business Associate of any limitation(s) in Covered Entity’s notice of privacy practices, to the extent that such limitation(s) may affect Business Associate’s use or disclosure of PHI.

6.2 Change or Revocation of Permission. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that such changes may affect Business Associate’s permitted or required uses and disclosures of PHI. Business Associate shall comply with any such changes or revocations.

6.3 Restrictions on Use or Disclosure. Covered Entity shall notify Business Associate of any restriction on the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent such restriction may affect Business Associate’s use or disclosure of PHI. Business Associate shall comply with any such restrictions. Business Associate shall immediately notify Covered Entity of any request for a restriction on the use or disclosure of an Individual’s PHI that Business Associate receives from such Individual.

6.4 No Request to Use or Disclose in Impermissible Manner. Except as necessary for the Data Aggregation Services or management and administrative activities of the Business Associate as allowed herein, Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

7. Term and Termination

7.1 Term. This Agreement shall be effective as of the earlier of the date first documented above or the effective date of the Services Arrangement, if applicable, and shall terminate upon termination of the Services Arrangement, if applicable, for any reason, or as otherwise provided in this Agreement.

7.2 Termination with Cause. Upon Covered Entity's knowledge of a material breach by Business Associate, its agents or subcontractors, Covered Entity shall, at its option: i) provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement if Business Associate does not cure the breach or end the violation as specified by Covered Entity; ii) immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and Covered Entity deems cure by Business Associate not to be possible; or iii) if neither termination nor cure are feasible, report the violation to the Secretary.

7.3 Effect of Termination.

(a) Except as provided in paragraph (b) of this Section, upon termination of this Agreement for any reason, Business Associate shall return or destroy (at Covered Entity's election), and shall retain no copies of, all PHI in the possession of Business Associate.

(b) In the event that Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to Covered Entity written notification of the conditions that make return or destruction infeasible. Upon Covered Entity's written approval, which shall not be unreasonably withheld, Business Associate may retain the PHI, but shall extend the protections of this Agreement (including, but not limited to, Sections 1 through 5) to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

8. Standards for Electronic Transactions. In connection with the Services to be provided to Covered Entity pursuant to this Agreement, Business Associate agrees that if it (or an agent or subcontractor) conducts an electronic transmission for which the Secretary has established a "standard transaction" under 45 C.F.R. Part 164, Subparts A, C, D and E, as applicable (the "*Electronic Transactions Standards*"), Business Associate (or its agent or subcontractor) shall comply with the requirements of the Electronic Transactions Standards. Business Associate specifically represents that it has obtained such compliance. Business Associate agrees that, in connection with the transmission of standard transactions, it will not (and will not permit any agent or subcontractor with which it might contract to): (i) change the definition, data condition, or use of a data element or segment in a standard; (ii) add any data elements or segments to the maximum defined data set; (iii) use any code or data elements that are either marked "not used" in the standard's implementation specification or are not in the standard's implementation specification; or (iv) change the meaning or intent of the standard's implementation specification(s). Business Associate understands that Covered Entity reserves the right to request an exception from the uses of a standard as permitted by 45 CFR § 162.940, and, if such an exception is sought, Business Associate agrees to participate in a test modification.

9. **Confidentiality of Business Information.**

9.1 **Business Information.** In the event the parties have not agreed to alternative confidentiality language with respect to business information exchanged between them, the following provisions will apply. Neither party will disclose to any third party any information related to this Agreement or to the business operations of the other party, or any proprietary information belonging to the other party (collectively, “***Confidential Business Information***”) without the prior written consent of the other party, except as may be required under law; provided that a party required by law to disclose Confidential Business Information shall inform the other party in order that the other party may contest such requirement. Each party hereby agrees that all Confidential Business Information communicated to it by the other party, whether oral or written, and whether before or after execution of this Agreement, was and will be received in strict confidence and will be used only for purposes set forth in the Services Arrangement or Section 3.1 hereof, as applicable. Upon termination of this Agreement, each party shall, upon the request of the providing party, promptly return all such Confidential Business Information to the providing party or, at the providing party’s option, shall destroy such Confidential Business Information and certify as to its destruction. This obligation of confidentiality shall not apply to information i) which was known by the recipient without the obligation of confidentiality prior to its receipt of such information; ii) is or becomes publicly available without breach of this Agreement; or iii) is received from a third party without an obligation of confidentiality and without breach of this Agreement. This paragraph shall not apply to uses and disclosures of PHI, which shall be governed by the remaining provisions of this Agreement.

9.2 **Response to Subpoena.** Business Associate shall be permitted to disclose PHI and Confidential Business Information that Business Associate is required to disclose pursuant to court order, subpoena or other compulsory legal process, provided that prior to making any disclosure thereunder, Business Associate shall provide Covered Entity within five (5) calendar days prior written notice (or as much notice as reasonably practicable under the circumstances) of the intended disclosure, specifying the basis and nature of the same.

10. **Miscellaneous.**

10.1 **Assignment; Waiver.** This Agreement shall be binding upon and inure to the benefit of the respective legal successors of the parties. Neither this Agreement nor any rights or obligations hereunder may be assigned, in whole or in part, without the prior written consent of the other party. Except as provided herein, this Agreement shall create no independent rights in any third party or make any third party a beneficiary hereof. No failure or delay by either party in exercising its rights under this Agreement shall operate as a waiver of such rights, or of any prior, concurrent, or subsequent breach.

10.2 **Property Rights.** All PHI shall be and remain the exclusive property of Covered Entity. Business Associate agrees that it acquires no title or rights to the PHI, including any de-identified information, as a result of this Agreement.

10.3 **Right to Cure.** Business Associate agrees that in the event Business Associate fails to cure a breach of this Agreement pursuant to this Agreement, Covered Entity has the right, but not the obligation, to cure the same. Expenses, costs or fines reasonably incurred in connection with Covered Entity’s cure of Business Associate’s breach(es) shall be borne solely by Business Associate.

10.4 **Injunctive Relief.** Business Associate agrees that breach of the terms and conditions of this Agreement shall cause irreparable harm for which there exists no adequate remedy at law. Covered Entity retains all rights to seek injunctive relief to prevent or stop any breach of the terms of this

Agreement, including but not limited to the unauthorized use or disclosure of PHI by Business Associate or any agent, contractor or third party that received PHI from Business Associate.

10.5 Survival; Severability. The respective rights and obligations of Business Associate under this Agreement, including but not limited to Business Associate's indemnification obligations, shall survive the termination of this Agreement. The parties agree that if a court determines that any of the provisions of this Agreement are invalid or unenforceable for any reason, such determination shall not affect the enforceability or validity of the remaining provisions of this Agreement.

10.6 Entire Agreement; Amendment. This document, together with any written Schedules, amendments and addenda, constitutes the entire agreement of the parties and supersedes all prior oral and written agreements or understandings between them with respect to the matters provided for herein. The parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the HIPAA Authorities and HIPAA. Any modifications to this Agreement shall be valid only if such modifications are in accordance with the HIPAA Authorities, are made in writing, and are signed by a duly authorized agent of both parties.

10.7 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Missouri to the extent that the HIPAA Authorities do not preempt the same.

10.8 Notice. Any notice required or permitted to be given by either party under this Agreement shall be sufficient if in writing and hand delivered (including delivery by courier) or sent by postage prepaid certified mail return receipt requested, to the following address:

If Covered Entity:

Name: Larry Keeley
Title: SVP of Operations
Company Name: OptiCare Vision Company, Inc.
Address: 112 Zebulon Court
Rocky Mount, NC 27804
Phone: (252) 451-2229

If Business Associate:

Name: _____
Title: _____
Company Name: _____
Address: _____
Phone: _____

10.9 Independent Contractors. For purposes of this Agreement, Covered Entity and Business Associate are and will act at all times as independent contractors. None of the provisions of this Agreement shall establish or be deemed or construed to establish any partnership, agency, employment agreement or joint venture between the parties.

Each party to this Agreement warrants that it has full power and authority to enter into this Agreement, and the person signing this Agreement on behalf of either party warrants that he/she has been duly authorized and empowered to enter into this Agreement.

COVERED ENTITY

BUSINESS ASSOCIATE

By: _____

By: _____

Title: SVP of Operations

Title: _____

Date: _____

Date: _____



OptiCare Vision Plans

OptiCare Vision Plans is required to file a Form 1099 with the Internal Revenue Service for each provider/vendor to whom \$600.00 or more has been paid for services in the course of a year. The IRS requires OEHN, as a payor, to provide via Form 1099 a provider/vendor name a tax identification number (TIN), and an amount paid for those provider/vendors meeting the above requirements. There is a reason for this. The IRS has found that a high rate of names and TINs submitted by payers, specifically medical service payers, do not match IRS records. This mismatch could potentially result in OEHN being required to withhold federal income tax up to 31% from your payments. To ensure that this mismatch does not occur, we are requesting that you complete the following Form W-9, providing us with an attestation of your TIN and provider/vendor name.

THE NAME AND TIN NUMBER REPORTED ON YOUR FORM 1099 MUST MATCH THE INFORMATION YOU REPORT ON FORM W-9 FOR YOUR ENTITY. If you need assistance, please contact your tax advisor. To ensure that your correct name and number are reported to the IRS, please read the directions on the Form W-9 before completing it. Failure to provide your TIN could potentially give rise to an IRS imposed penalty of \$50.00 up to a maximum of \$100,000.00.

As a part of your credentialing/recredentialing process, please complete the Form W-9 below and return it with your paperwork.

A form W-9 must be completed for each unique tax ID and/or reflect any changes in name, business name, primary address or TIN. The primary address associated with the TIN should be denoted. Please make additional copies if necessary.

Form W-9 (Rev. January 2002) 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.
Please print or type See Specific Instructions on page 2	Name	
	Business name, if different from above	
	Please check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other ⇒ _____ <input type="checkbox"/> Exempt from backup withholding	
	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. 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 2. 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 2.		Social security number <input style="width: 100%; height: 20px;" type="text"/>
or		Employer identification number <input style="width: 100%; height: 20px;" type="text"/>
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. person (including a U.S. resident alien).		
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 2).		
Sign Here	Signature of U.S. person ⇒	Date ⇒