Insured Client and Benefit Advisor Acknowledgement Form

Insured, Non-Guaranteed Cost (i.e., Shared Returns) Medical, Dental, Vision and Stop-Loss products offered by one or more insurance or HMO subsidiaries of Cigna Corporation (collectively "Cigna")

Insured Guaranteed Cost Medical, Dental, Vision and Stop-Loss Cigna products when benefit advisor compensation is to be included in Cigna premium rates

Acknowledgement of Benefit Advisor Designation

Account (number) _____, Client (name) _____ hereby acknowledges that the individual/firm listed below has been designated by Client as its broker of record/ consultant ("**Benefit Advisor**") as of: _____.

Client shall promptly notify Cigna of a change in the Benefit Advisor designation. Benefit Advisor changes are effective the first of the month following the month in which notification is received by Cigna.

Confirmation of Benefit Advisor Compensation

Client has agreed that Benefit Advisor shall be compensated as indicated in the Compensation Details below (the "Benefit Advisor Compensation").

Client shall promptly notify Cigna of any change in the Benefit Advisor Compensation.

Client hereby authorizes Cigna to act as its agent in paying the Benefit Advisor Compensation identified in the Compensation Details to its designated Benefit Advisor.

Note: If the Benefit Advisor Compensation is based upon a percentage of premium, a premium equivalent will be used in determining the Benefit Advisor Compensation with respect to a "Minimum Premium" policy.

Additional Terms

This document constitutes the entire understanding and agreement of the parties and supersedes any prior agreement or understanding between them with regard to the subject matter hereof. The terms of this document can only be changed or waived by the mutual, written consent of the Client, the Benefit Advisor and Cigna.

Note: No payment will be made to the Benefit Advisor unless the Benefit Advisor (individual and agency) has a contract with Cigna, holds an appropriate resident or non-resident license and is appointed with Cigna.

COMPENSATION DETAILS

Client Name:	Client Situs State: Alabama

Product	Effective Date of Product	Per Employee	Employee Plus 1/ Spouse	Employee Plus 2/ Child	Employee Plus 3/ Family	Annual or Monthly Flat Amount	Percentage of Premium

CLIENT INFORMATION

By signing below, you are confirming that you have agreed to the preceding terms and the Compensation Details outlined above.

Authorized Client *(Print)*:	Client SSN or Tax ID:
Authorized Client Signature:	Date:

WRITING PRODUCER/BENEFIT ADVISOR INFORMATION

Writing Producer Name *(Print)*:	Last 4 digits of SSN or full Tax ID:	Percentage of Compensation:
Writing Producer Signature:	Date:	

Checks made payable to:

Individual/Agency Name *(Print)*:	Benefit Advisor/Agency Account Number:

Compensation Mailing Address *(Street/P.O. Box)*: *(City)*: *(State)*: *(Zip Code)*:

Last 4 digits of SSN or full Tax ID:	Phone Number:	Email Address:

GENERAL AGENCY INFORMATION *(if applicable)*

General Agency Name *(Print)*:	General Agency Account Number:

General Agency Mailing Address *(Street/P.O. Box)*: *(City)*: *(State)*: *(Zip Code)*:

Sub-Agent or Employee Name *(Print)*:

Sub-Agent or Employee Signature:	Date:

COMPLETE IF MORE THAN ONE PRODUCER

Client Name:

Writing Producer Name *(Print)*:	Percentage of Compensation:
Writing Producer Signature:	Date:

Checks made payable to:

Individual/Agency Name *(Print)*:	Benefit Advisor/Agency Account Number:

Compensation Mailing Address *(Street/P.O. Box)*: *(City)*: *(State)*: *(Zip Code)*:

Last 4 digits of SSN or full Tax ID:	Phone Number:	Email Address:

Clear Form