

**Personal Data Form**

The State Life Insurance Company  
P.O. Box 406  
Indianapolis, IN 46206  
(317) 285-2300



Full Legal Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Home Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone No.: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

*(Important - For Notification of Code Number)*

Name of Corporation/Partnership: \_\_\_\_\_

*(If different from above, print name exactly as you wish it to appear on all company contracts, pay statements and promotional releases.)*

Mailing Address (PO Box): \_\_\_\_\_ Shipping Address (Street Address): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Business Phone: \_\_\_\_\_ Fax No.: \_\_\_\_\_

If the answer to any of these questions is "YES," list the number and please provide a separate letter of explanation with dates and supporting documentation.

YES NO

- \_\_\_\_ 1. Have you ever been a party to a bankruptcy or receivership proceeding involving your personal or business related debts?
- \_\_\_\_ 2. Have you had or are you currently the subject of any personal or business tax liens, suits or judgments?
- \_\_\_\_ 3. Has any insurance company ever terminated any agency, agent or broker contract with you for reason other than insufficient sales?
- \_\_\_\_ 4. Have you ever been the subject of any inquiry or proceeding by any state insurance department?
- \_\_\_\_ 5. Has any person ever complained to an insurance department or other agency about your conduct as an agent?
- \_\_\_\_ 6. Has your insurance agent's license ever been suspended or revoked or have you ever been denied a license?
- \_\_\_\_ 7. Have you ever had a surety or fidelity bond declined or cancelled?
- \_\_\_\_ 8. Have you been convicted for any offense other than a minor traffic violation?
- \_\_\_\_ 9. Have you been trained on needs-based selling or financial needs analysis?

For The State Life Insurance Company to be able to file an information return with the IRS, we must obtain your correct Taxpayer Identification Number (TIN) to report income paid to you. Please provide and certify your Social Security Number (mandatory) and if applicable, your Federal I.D. # below.

SSN: \_\_\_\_\_ Federal I.D. # (If Contracting Agency): \_\_\_\_\_

Check appropriate box:  Individual/Sole Proprietor  Corporation  Partnership  Other \_\_\_\_\_

**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. (3) I am a US person (including a US resident alien).

**FAIR CREDIT REPORTING ACT NOTICE**

As part of the procedure for processing your application, an investigative consumer report may be made. (Some insurance departments require such a report.) This report may include information as to your character, general reputation and personal characteristics; this information is normally obtained through personal interviews and employment verification. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation.

I hereby certify that the information I have provided on this form is complete and accurate, and you have my permission to contact present and past companies I have been contracted with (unless otherwise indicated) and references to verify any information in establishing my qualifications. I understand that, if appointed, my contracting will be contingent upon my being properly licensed to represent State Life.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

**Producer Contract Agreement**  
Long Term Care Insurance

Products and financial services provided by  
The State Life Insurance Company  
a ONEAMERICA® company  
P.O. Box 406  
Indianapolis, IN 46206  
(317) 285-2300



**Producer Appointee:** \_\_\_\_\_

**Recruiter:** \_\_\_\_\_

**Recruiter's State Life Code:** \_\_\_\_\_

The State Life Insurance Company hereby appoints the aforementioned Producer Appointee as its **PRODUCER** with duties, powers, and obligations as herein set forth, and you hereby accept the appointment on the terms and conditions set forth herein. The provisions stated in all supplements, commission rules, the Schedule of Commissions found in the Commission Schedule Forms listed below are a part of this Agreement. You have received, read, understand, and agree to abide by Producer Contract (**Form #SL-139**), which is incorporated herein by reference.

**Effective Date** – This Agreement shall become effective on \_\_\_\_\_. If any provision of the Agreement is now or shall in the future be in conflict with any applicable law or any valid Department of Insurance ruling or order, it shall be modified to the extent necessary for compliance. This Agreement shall supersede all previous agreements between the parties.

LTCI Compensation Schedule (**Form # \_\_\_\_\_**)

**or, in lieu of above schedule:**

Producer Licensed Only Agreement (**Form # SL-099**)(attached)

The parties agree that facsimile signatures shall be deemed to be originals, and both parties agree to accept facsimile signatures and to be bound thereby.

**Producer**

By: \_\_\_\_\_  
(Producer's Signature)

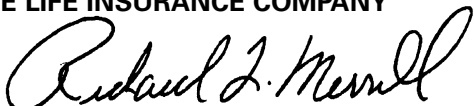
Date: \_\_\_\_\_

**If Corporation:**

By: \_\_\_\_\_  
(Officer's Signature)

Date: \_\_\_\_\_

**THE STATE LIFE INSURANCE COMPANY**

By:  \_\_\_\_\_  
(President)

**If Partnership:**

By: \_\_\_\_\_  
(Partner's Signature)

By: \_\_\_\_\_  
(Partner's Signature)

Date: \_\_\_\_\_

**Please complete and return this form to Home Office**

# Commission Direct Deposit Form

The State Life Insurance Company  
P.O. Box 406  
Indianapolis, IN 46206



## THIS FORM WILL AUTHORIZE STATE LIFE TO:

- Direct deposit your commission payment checks

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## Direct Deposit of your Commission Payments (Long Term Care Insurance Only)

I hereby authorize The State Life Insurance Company to initiate credit entries to my bank account in the Depository Institution named below, and I authorize the Depository Institution to accept and credit the amount of such entries to my account.

**Complete the information requested below and return to Home Office *along with a voided check***

Depository Institution: \_\_\_\_\_

Depository Institution's Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Routing #: \_\_\_\_\_ Account #: \_\_\_\_\_

Account Type:      Checking       Savings

This authorization is to remain in full force and effect until the Company has received written notification from me of its termination in such time and in such manner as to afford the Company a reasonable opportunity to act on it.

Name: \_\_\_\_\_

Agent Code Number: \_\_\_\_\_ SSN or Tax ID#: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Email Address (Required): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***Commission Statement will be e-mailed on the 15th and the last day of each month  
Each transaction will be limited to a minimum of \$10.00***