EVT
EMPLOYERS GROUP TRUST - VISION

SERVICE FEE AGREEMENT

Service fees will be paid monthly, beginning on the effective month of the insurance or anniversary thereof. Each monthly payment will be determined by applying the following schedule to the collected monthly premium.

SERVICE FEE SCHEDULE

Rates of Fees For All Premium Amounts: 2-1,000 lives - 10%

All service fees will be paid so long as; (i) you are licensed by the applicable State Insurance Department to see the insurance provided by the policy; (ii) you service the business; (iii) the policyholder recognizes you as the agent or broker of record; (iv) premium is paid; (v) the policy remains in force; and (vi) our current rates and procedures remain unchanged. All administrative fees are excluded from this agreement. Service fee payments are released when the total fee payable meets or exceeds $50.

Any indebtedness of the Agent/Agency to EVT shall be a first lien against any service fees due the Agent/Agency or his assignees under this agreement. No assignment, transfer or disposal of any interest that the Agent/Agency may have on account of this agreement shall be made at any time without the written approval of EVT.

It is understood that the Agent/Agency is not authorized to incur any indebtedness in the name of EVT or to sign the name of EVT to any contracts.

It is further understood the Agent/Agency is an independent contractor and nothing contained herein shall be construed to create the relation of employer and employee between EVT and Agent/Agency.

The cashing of the first compensation check issued constitutes acceptance of this Service Fee Agreement.

This agreement shall be governed by and construed under the laws of the State of Connecticut.

IN WITNESS WHEREOF, the parties have caused this agreement to executed at Shelton, CT.

Recipient hereby certifies that he/she is licensed to see the above insurance in the state of _____ , the state in which the above Policy is issued, License Number _____ , effective _____ year _____ .

REMINDER: Attached copy of your current accident and health license and proof of errors and omissions coverage certificate from the state where the case was written.

***If service fees are split, each recipient must complete a Service Fee Agreement.**

Commission payable to:	
Print Name of Recipient/Agent:	
Signature:	Date:
Agent Mailing Address (Please Print):	
Telephone Number:	E-mail Address:
Social Security No. or Federal ID No.	Fax Number:
By: AmWINS Group Benefits, Inc., Trust Administrator	Date: