



COMPENSATION ACKNOWLEDGMENT FORM

(CAF- 4)

| | | |
|-------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| To be completed by: Field Sales and Producer | Segment: <input type="checkbox"/> Small Case <input type="checkbox"/> Mid-Market <input type="checkbox"/> National | Contract/Situs State(s): _____ Are there any NY HMO or POS members? Yes <input type="checkbox"/> No <input type="checkbox"/> Are there any Virginia CHMO or DHMO members? Yes <input type="checkbox"/> No <input type="checkbox"/> |
|-------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

| Account Name | All Account Numbers* | HMO Site | Coverage Name | Comp. Eff. Date | Estimated Annual Premium | Total Producer Account Comp Rate | Producer Share % | \$ Flat Amt (Not for Small Case and CDH) |
|--------------|----------------------|----------|---------------|-----------------|--------------------------|----------------------------------|------------------|------------------------------------------|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

*Please Indicate Healthsource Provident Account Number if Applicable

All commission levels are subject to Underwriting approval. Any commission levels that exceed legal limits will be reduced. Flat percentages or dollar amounts may be adjusted during the policy year in response to fluctuations in premium.

| | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Producer Name (Signature) _____ Date _____ Producer Name (Print) _____ SSN _____ Birth Date _____ (Must hold appropriate resident or non resident license & appointment) Firm Name _____ Street Address, P.O. Box # _____ City _____ State _____ ZIP _____ Phone Number _____ FAX Number _____ E-Mail Address _____ | ****CHECKS ARE TO BE MADE PAYABLE TO**** Producer or Firm Name (Print) _____ SSN/TAX ID _____ (Must hold appropriate resident or non resident license & appointment) ****GENERAL AGENCY (if applicable)**** Total GA Account Comp Rate _____ General Agent Name _____ Tax ID# _____ |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

| | | | |
|----------------------------------|------------------------|--------------------------------|--------------------|
| Representative's Signature _____ | Date _____ | Underwriter's Signature _____ | Date _____ |
| Representative (Print) _____ | | Underwriter Name (Print) _____ | |
| Sales Office _____ | Telephone Number _____ | Underwriter Office _____ | Phone Number _____ |

Connecticut General Life Insurance Company
 CIGNA HealthCare, Healthsource, Inc., and CIGNA Dental Health

To comply with New York's four percent (4%) limit on compensation paid to brokers on HMO contracts, CIGNA HealthCare will not pay more than four percent (4%) commissions on HMO, POS (formerly CHA), POS Open Access and HMO Open Access products for membership covered by CIGNA Healthcare of New York, Inc.