



OFFICE OF INSURANCE REGULATION

Company Admissions

**APPLICATION FOR PROVISIONAL CERTIFICATE OF AUTHORITY
CONTINUING CARE RETIREMENT COMMUNITY**

This package is designed to assist individuals in preparing the Application for Provisional Certificate of Authority (PCOA). It may be used by a legal entity wishing to engage in the business of providing continuing care or issuing continuing care contracts or construct a facility for the purpose of providing continuing care. This application includes five (5) categories of information:

- Section I Application Forms and Related Fees
- Section II Legal
- Section III Financial
- Section IV Management
- Section V Forms

Please submit the application in a binder that has been two-hole punched at the top. Place the tabs at the bottom of the documents, e.g. Tab labeled III-1 would contain the Plan of Operations.

Submit the completed application to:

Office Of Insurance Regulation
Company Admissions
200 East Gaines Street, Larson Building
Tallahassee, Florida 32399-0332

In order for a submission to be considered a complete application, all required information must be included in the filing. Filings that do not include all required information will be disapproved or returned.

**DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
APPLICATION FOR PROVISIONAL CERTIFICATE OF AUTHORITY
CONTINUING CARE RETIREMENT COMMUNITY**

**INSTRUCTIONS
SECTION I - APPLICATION FORM AND RELATED FEES**

Section I-1 Application Fees

Applicants must pay an application-filing fee of \$50. The fee is due at the time the application is filed. Secure the check to the invoice (included in this package) and send to:

Florida Department of Financial Services
Bureau of Financial Services
PO Box 6100
Tallahassee, Florida 32314-6100

Place a photocopy of the invoice and check in this section.

Section I-2 Fingerprint Processing Fees

Applicants are required to prepay electronically for the processing of the fingerprint cards required in section IV-5. Please see form OIR-C1-938 for instructions. The fingerprint cards are to be submitted with the application filing.

Place a copy of your on-line payment confirmation along with the fingerprint cards in the management section (IV-5).

NOTE: Florida residents have the option of having their fingerprints digitally scanned rather than providing paper fingerprint cards. Please see form OIR-C1-938 for instructions.

NOTE: Individuals who are non-U.S. citizens with no social security number should continue to submit payment of fingerprint fees per instructions in form OIR-C1-903.

Section I-3 Application for Provisional Certificate of Authority

Submit this original Application for PCOA, attested (original signatures) by the President, Partners, Managing General Partner, Association Members or Trustee, etc. and, if applicable, the secretary of the company under corporate seal and notarized. Upon approval, the Office of Insurance Regulation (the Office) will issue a PCOA to you.

**DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
APPLICATION FOR PROVISIONAL CERTIFICATE OF AUTHORITY
CONTINUING CARE RETIREMENT COMMUNITY**

SECTION II - LEGAL

Section II-1 Authorization Letter

Provide a letter of authorization for anyone other than company personnel or the company-sponsoring agent, designating the named individual to represent the applicant.

Section II-2 Articles of Incorporation

Provide the articles of incorporation and all amendments of the company, if applicable, with an original certification by the public official with whom the originals are on file in the state of domicile.

Section II-3 Company Bylaws

Provide the bylaws and all amendments of the company, if applicable, signed and dated by the secretary of the company under corporate seal.

Section II-4 Certificate of Status from Florida Secretary of State

Provide an original Certificate of Status issued by the Florida Secretary of State, if applicable, demonstrating that the company is in good standing.

Section II-5 Fictitious Name Filing

Provide documentation of your compliance with Section 865.09, Florida Statutes (FS), dealing with fictitious names, if the applicant plans to utilize a fictitious name. Contact the Florida Secretary of State at the following telephone number for assistance in complying with these requirements (850) 488-9000. Please provide the original, if applicable.

Section II-6 Partnership Agreements

Provide a certified, notarized copy of the original executed partnership agreement and all amendments, if applicable, signed and dated by the managing general partner. Should general partners or managing general partners be corporations, they must submit organizational documents required in Sections II-3 through II-6, above.

Section II-7 Parent Companies and Controlling Partners

Provide complete organizational documents required in Sections II-2 through II-6, for all entities controlling the applicant upward to the ultimate controlling entity.

Section II-8 Association Membership, or Trust Agreements

Provide a certified original association membership agreement, trust agreement, or other legal entity, and all amendments, if applicable, signed and dated by the appropriate representative.

**DEPARTMENT OF FINANCIAL SERVICES
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APPLICATION FOR PROVISIONAL CERTIFICATE OF AUTHORITY
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SECTION III - FINANCIAL

Section III-1 Plan of Operations

Submit a general summary of the plan of operations from receipt of the PCOA through occupancy of facility. Review the general information attached as exhibit III-1.

Section III-2 Organizational Chart

Provide a schematic external organizational chart disclosing the applicant's relationship with any other entities, including the ultimate controlling company or controlling person. Label all appropriate ownership percentages.

Section III-3 Interrogatories

Submit complete responses to all interrogatories attached as exhibit III-3.

Section III-4 Proof Of Ownership, Rights To Operation Or Management

If the applicant is the owner of the proposed facility site, attach a copy of the warranty deed or contract for deed. If the applicant intends to operate the facility, attach a copy of the proposed operating agreement. If the applicant intends to manage or employ a management company to manage the facility, attach a copy of the proposed or executed management agreement.

Section III-5 History In The Industry

Provide a list of all continuing care facilities currently or previously owned, operated, managed or developed by the applicant; any affiliate of the applicant; any entity controlling or controlled by the applicant, or any principal thereof. Furnish the name, address, city, and state of each facility listed and explain the existing or past relationship to the applicant. Specify the current status of each facility listed, and include any administrative actions or financial problems that exist or which existed. Include any such occurrences up to one year after the relationship was terminated. (The Office shall request such other reasonable data, including financial statements, to assist in determining the financial viability of the project and the management capabilities of its managers, owners or operators based on its review of the contents of this application response pursuant to Chapter 651, FS.)

Section III-6 Feasibility Study

Attach a statement outlining the credentials and experience of the person who prepared the feasibility study. Attach a copy of the market feasibility study attested to by the preparer and an attestation by the appropriate officers, directors, partners or shareholders that the study is "true and complete." The market feasibility study must contain all information to comply with Sections 651.022(3)(a)-(h), FS.

Section III-7 Project Financing

Provide a complete explanation of the project's proposed method of financing. Include a "Sources and Uses of Funds Statement," which discloses all sources and all uses of funds to be used to develop the project. The statement should reflect that the aggregate amount of entrance fees received by or pledged to the applicant, plus anticipated proceeds from any long-term financing commitment, plus funds from all other sources in the actual possession of the applicant, equal to not less than 100 percent of the aggregate cost of constructing or purchasing, equipping, and furnishing the facility plus 100 percent of the anticipated startup losses of the facility. Submit copies of all proposed, drafted or executed financial agreements. Upon final execution, copies of any such documents must be sent to the Office within 30 days.

Section III-8 Advertising

Attach a copy of all advertising proposed to be used in marketing the facility.

Section III-9 Contracts, Vendors, Services

Identify and explain how and by whom the following goods and services will be furnished, and the relationship, if any, to the applicant. If the party furnishing such services is other than the applicant, attach a copy of the contract or agreement, or other documents which evidences the arrangement, and state whether or not the contract or arrangement is the result of "arms length" negotiations, a bid, or, if otherwise explain: a. Shelter; b. Food; c. Health Care; d. Management; e. Construction; f. Construction financing; g. Permanent financing; h. Land; and i. Marketing.

Section III-10 Financial Statements

Attach the latest audited financial statement for the applicant and any controlling parent company. Also include the unaudited financial statements for the most recent quarter ended subsequent to the date of the last audit and attested to by the Chief Financial Officer. (The Office shall request such other reasonable data and financial information to assist in determining the financial viability of the applicant and the management capabilities of its managers and owners based on its review of the contents of this application response pursuant to Chapter 651, FS.)

**DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
APPLICATION FOR PROVISIONAL CERTIFICATE OF AUTHORITY
CONTINUING CARE RETIREMENT COMMUNITY**

SECTION IV - MANAGEMENT

ANY INDIVIDUALS MUST PROVIDE ALL OF THE INFORMATION REQUESTED. NAMES REQUESTED IN THIS SECTION SHOULD INCLUDE FIRST, MIDDLE AND LAST NAMES (NO ABBREVIATIONS).

Section IV-1 Management Information

Provide the full name of all company incorporators, officers, directors, shareholders (owning 10% or more of the outstanding stock of the company), partners, proprietor, management company principals, association members and/or trustees with their respective titles and where appropriate, ownership percentages. Please use the attached Management Information Form. If any shareholder with 10% or more of the stock is not an individual, then the same information should be provided for all principals up through the ultimate controlling person.

Section IV-2 Biographical Affidavits by All Company Incorporators, Officers, Directors, Shareholders, Partners, Proprietor, Management Company Principals, Association Members and Trustees

Provide a Biographical Affidavit (Form OIR-C1-1423) for each officer, director, and shareholder listed in Section IV-1 except for those companies in the organizational structure between the immediate parent and the ultimate parent. All questions must be answered. If, however, the Biographical Affidavits are currently on file and are not more than two years old, no submission is necessary.

The requirement for the affiant's social security number as part of the Biographical Affidavit is mandatory. However, Pursuant to Sections 119.071(5), FS, social security numbers collected by an agency are confidential and exempt from section 119.07(1), FS, and Section 24(a), Art. 1 of the State Constitution and must be segregated on a separate page. Therefore, instead of including the SSN on page 6 of the NAIC form, please include the affiant's name and social security number on a separate page and attach it to the Biographical Affidavit. Also, please stamp CONFIDENTIAL at the top and bottom of the separate page.

Section 119.071(5), FS, gives authority for an agency to collect social security numbers if imperative for the performance of that agency's duties and responsibilities as prescribed by law. Limited collection of social security numbers is imperative for the Office of Insurance Regulation. The duties of the Office of Insurance Regulation in background investigation are extensive in order to insure that the owners, management, officers, and directors of any insurer are competent and trustworthy, possess financial standing and business experience, and have not been found guilty of, or not pleaded guilty or nolo contendere to, any felony or crime punishable by imprisonment of one year.

Section IV-3 Background Investigative Report

An Investigative Background Report must be provided for each person listed in Section IV-1 above except for those companies in the organizational structure between the immediate parent and the ultimate parent. Background reports must be submitted by the selected background investigator vendor directly to the Office prior to or contemporaneously with the submission of the application filing. Please refer to form OIR-C1-905 for instructions.

Section IV-4 Fingerprint Cards

Fingerprint cards must be completed for each person listed in Section IV-1. The cards will be furnished by the Office upon request. **No cards other than those furnished by the Office will be accepted.** The cards must be completed at a law enforcement agency and returned to this Office for processing. Please refer to form OIR-C1-938 for instructions.

Due to the length of time required by law enforcement agencies to process fingerprint cards, it is suggested that the cards be ordered immediately so they may be submitted before or with the application.

Please place the completed fingerprint cards in this section.

Note: Florida residents have the option of having their fingerprints digitally scanned rather than providing paper fingerprint cards and fees as noted above. Please refer to form OIR-C1-938 for instructions.

**DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
APPLICATION FOR PROVISIONAL CERTIFICATE OF AUTHORITY
CONTINUING CARE RETIREMENT COMMUNITY**

SECTION V - FORMS

Section V-1 Escrow Agreements

Submit a draft copy of the entrance fee escrow agreement, the seven-day escrow agreement and draft copies (copy) of the minimum liquid reserve escrow agreements. Escrow agreements must comply with Sections 651.033 and 651.035, FS, and Rule 69O-193.023, Florida Administrative Code (FAC), as appropriate. After Office review and any revisions are made, if necessary, three original escrow agreements executed by the applicant and escrow trustee must be submitted for Office signature.

Section V-2 Reservation and Residency Contracts

Applicant must provide copies of their proposed reservation and residency contracts for Office review and approval. Contracts must comply with Sections 651.055 and 651.061, FS, and Rule 69O-193.020, FAC.

**DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
APPLICATION FOR PROVISIONAL CERTIFICATE OF AUTHORITY
CONTINUING CARE RETIREMENT COMMUNITY**

**CHECK LIST
SECTION I - APPLICATION FORM AND RELATED FEES**

Company Name: _____

<u>Item #</u>	<u>Completion Check List</u>
1. Application fees paid	[]
(a) Copy of invoice included.....	[]
(b) Copy of check.....	[]
2. Fingerprint fees paid electronically	[]
(a) Copy of on-line payment confirmation	[]
Or, if applicable	
(b) Copy of form OIR-C1-903 (Invoice) included	[]
(c) Copy of check included	[]
(d) Originals mailed to Bureau of Financial Services	[]
3. Completed Application for Provisional Certificate of Authority	[]
(a) Attested under corporate seal of company and notarized	[]
(b) Signed by (original signatures)	
1. President or chief executive officer.....	[]
2. Secretary	[]
3. Partners	[]
4. General Partners	[]
5. Managing General Partner	[]
6. Association Members	[]
7. Trustee	[]
8. Proprietor or Other (Explain)	[]

**DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
APPLICATION FOR PROVISIONAL CERTIFICATE OF AUTHORITY
CONTINUING CARE RETIREMENT COMMUNITY**

SECTION II - LEGAL

Company Name: _____

<u>Item #</u>	<u>Completion Check List</u>
1. Authorization letter.....	[]
2. Articles of Incorporation including all amendments thereto	[]
(a) Original	[]
(b) Original certification by the public official with whom the originals are on file in the state of domicile (if foreign)	[]
(c) Board minutes recording approval of amendments	[]
3. Company bylaws including all amendments thereto	[]
(a) Original	[]
(b) Under corporate seal of company	[]
(c) Board minutes recording approval of amendments	[]
(d) Signed and dated by secretary	[]
4. Original certificate of status issued by the Florida Secretary of State evidencing registration as a foreign or domestic corporation.....	[]
(a) Original	[]
5. Fictitious Name Certificate (if applicable)	[]
(a) Original	[]
6. Partnership agreements including all amendments thereto	[]
(a) Original	[]
(b) Certified and signed by general partners, managing general partner.....	[]
7. Parent companies and controlling partners	[]
(a) Appropriated organizational documents (See Sections II-3 through II-7).....	[]
(b) Originals of each	[]

- 8. Association membership or trust agreements including all amendments []
 - (a) Association agreement original []
 - (b) Trust agreement original []
 - (c) Amendments to agreements []

**DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
APPLICATION FOR PROVISIONAL CERTIFICATE OF AUTHORITY
CONTINUING CARE RETIREMENT COMMUNITY**

SECTION III - FINANCIAL

Company Name: _____

<u>Item #</u>	<u>Completion Check List</u>
1. Plan of operations.....	[]
2. Organizational chart.....	[]
3. Interrogatories.....	[]
(a) Completed exhibit III-3 included in application.....	[]
4. Proof of ownership or rights to operation.....	[]
(a) Warranty deed or contract for deed.....	[]
(b) Operating agreement.....	[]
(c) Executed or draft of management agreement.....	[]
5. List of affiliated facilities including all specified information.....	[]
6. Feasibility Study.....	[]
(a) Statement outlining preparer's qualifications.....	[]
(b) Attested feasibility study.....	[]
(c) Applicant's attestation of feasibility study accuracy.....	[]
7. Project financing.....	[]
(a) Method of financing summary.....	[]
(b) Sources and Uses Statement.....	[]
(c) All proposed, drafted and executed financing agreements.....	[]
8. All proposed advertising.....	[]
9. Contracts, vendors, services	[]
(a) Copies of furnished service contracts (designating bid or non-bid)	[]
(b) Explanation of any affiliated or close handed agreements	[]

10.	Financial Statements	[]
	(a) Most recent audited financial statements	[]
(1)	Licensee	[]
(2)	Parent or controlling entity(ies).....	[]
	(b) Most recent unaudited quarterly financial statements	[]
(1)	Licensee	[]
(2)	Parent or controlling entity (ies)	[]
	(c) Attestation of Chief Financial Officer to (b)	[]

**DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
APPLICATION FOR PROVISIONAL CERTIFICATE OF AUTHORITY
CONTINUING CARE RETIREMENT COMMUNITY**

SECTION IV - MANAGEMENT

Company Name: _____

<u>Item #</u>		<u>Completion Check List</u>
1	Listing of all proposed company incorporators, officers, directors, shareholder, partners, proprietor, mgt. co. principals, association members and trustees (official form).....	[]
2.	Biographical Statement and Affidavits by incorporators, officers, directors, shareholders, partners, proprietor, mgt. co. principals, assn. Members and trustees (official form)..	[]
	As to each biographical:	
	(a) All information completed.....	[]
	(b) Contains original signature.....	[]
	(c) Notarized (original).....	[]
	(d) Original	[]
	(e) Provide SSN on separate page.....	[]
3.	Investigative Background Report for each individual listed in Section IV-1	[]
4.	Two fingerprint cards enclosed for each person listed in Section IV-1.....	[]
	As to each fingerprint card:	
	(a) Contains original signature of each respective officer.....	[]
	(b) Card obtained from the office of Insurance Regulation.....	[]
	(c) All information completed (DOB, citizenship, vital statistics).....	[]

**DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
APPLICATION FOR PROVISIONAL CERTIFICATE OF AUTHORITY
CONTINUING CARE RETIREMENT COMMUNITY**

SECTION V - FORMS

Company Name: _____

<u>Item #</u>	<u>Completion Check List</u>
1. Escrow agreements	[]
(a) Entrance fee escrow agreement	[]
(b) Seven-day escrow agreement	[]
(c) Minimum liquid reserve escrow agreements	[]
(1) Debt Service Reserve	[]
(2) Operating Reserve.....	[]
(3) Renewal and replacement Reserve.....	[]
2. Reservation and residency contracts	[]
(a) Reservation contracts	[]
(b) Residency contracts	[]

**THE COMPLETED CHECKLIST MUST BE RETURNED WITH THE APPLICATION
PACKAGE.**

**DEPARTMENT OF FINANCIAL SERVICES
FLORIDA OFFICE OF INSURANCE REGULATION**

CHECKLIST VERIFICATION

The undersigned says that he/she is a senior officer having personal knowledge of the application submitted to the Florida Office of Insurance Regulation in connection with licensure sought by

(Entity Name)

that he/she has read said application, that he/she knows the contents thereof and verifies that the items indicated in the application checklist have been submitted with the application, that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument, the applicant on behalf which the person acted, executed the instrument.

I understand that whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his or her official duties is guilty of a misdemeanor of the second degree, pursuant to Section 837.06, Florida Statutes.

Dated _____

(Give full and exact name of Applicant)

Signature of President, Secretary, or Treasurer

Printed Name

Printed Title

INVOICE

**DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
CONTINUING CARE RETIREMENT COMMUNITY
APPLICATION FOR PROVISIONAL CERTIFICATE OF AUTHORITY**

NAME OF COMPANY: _____

FEIN _____

ADDRESS: _____

CITY, STATE & ZIP CODE: _____

PHONE NUMBER: (____) _____ - _____

MAILING ADDRESS (IF DIFFERENT FROM STREET ADDRESS)

_____ (CITY) (STATE) (ZIP CODE)

Type of Entity: Stock corporation, non-profit corporation, general partnership, limited partnership, proprietorship, association, or trust.

1. Make check payable to the Office of Insurance Regulation and mail check and invoice only to the Office of Insurance Regulation, Bureau of Financial Services, Post Office Box 6100, Tallahassee, Florida 32314-6100.
2. Include a copy of the check and the invoice in Section I-1 of your application. The completed application package should be submitted to the Office of Insurance Regulation, Applications Coordination Section, 200 E. Gaines Street, Larson Building, Tallahassee, Florida 32399-0332.

	B/T	TY/CL	F/T	AMOUNT
Filing Fee	C	12/26	F	<u>\$50.00</u>
			Total	\$50.00

DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
TALLAHASSEE, FLORIDA 32399-0300

APPLICATION FOR PROVISIONAL CERTIFICATE OF AUTHORITY TO PROVIDE
CONTINUING CARE IN THE STATE OF FLORIDA

_____, 20_____
TO THE DIRECTOR OF INSURANCE REGULATION OF THE STATE OF FLORIDA,
TALLAHASSEE, FLORIDA

SIR:

The _____
(Give name of company, partnership, proprietorship, trust or association in full)

Type of Entity: Stock corporation, non-profit corporation, general partnership, limited partnership,
proprietorship, association, or trust. _____

Federal Employer's Identification Number _____

of _____
(Home Office Address) (City) (State) (Zip)

Phone Number: () _____ - _____ Fax: () _____ - _____

E-Mail Address: _____

through its duly authorized officers, hereby applies for license authorizing and empowering the Company,
Partnership, Trust, or Association aforesaid to transact continuing care in the state of Florida, under the
laws thereof.

ATTESTATION

I do solemnly attest that I am familiar with Chapter 651, Florida Statutes, relating to Continuing
Care Contracts, and that all the responses, information, exhibits and documentary evidence submitted
are true and correct to the best of my knowledge, information and belief.

By _____
President, Managing General Partner, Partner, Trustee, etc.

(Corporate Seal, if applicable)

Attest _____
Secretary

State of _____

County of _____

Sworn to and subscribed before me this
_____ day of _____, _____

(Notary Seal)

Notary Public

**DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
CONTINUING CARE RETIREMENT COMMUNITY
APPLICATION FOR PROVISIONAL CERTIFICATE OF AUTHORITY
EXHIBIT III-1**

GENERAL INFORMATION

I. **GOVERNING LAW AND RULES:** Continuing Care Providers are regulated pursuant to Chapter 651, FS, Rule 69O-193, FAC, and various provisions of the Florida Insurance Code which are incorporated by reference in Chapter 651, FS.

II. **FORMS:** A. All forms required to be submitted to the Office are contained in Office Rule 69O-93.065, FAC. No other forms will be accepted by the Office. B. When completing any Office form, if the space provided is insufficient for a full and complete response and additional space is necessary, attach a separate sheet, or provide the necessary documentation, cross-referenced to the specific item or question asked.

III. **APPLICATIONS:** A. Upon PCOA application approval you will be issued a facility file number (company number). This number will remain with you as long as you are an applicant or a Certificate holder. All correspondence with the Office must reference this facility file number. B. Providers with more than one facility in this state must reference the individual facility file number assigned to a specific facility when corresponding with the Office about that facility.

IV. **CERTIFICATIONS OR ATTESTATIONS:** When certifications or attestations are referenced in the applications, they generally will have the following meanings: A. In connection with organizational documents, certification must be from the Florida Secretary of State or the equivalent public official from the State of Domicile, if different than Florida. Where Corporate bylaws etc. are required, certification by the Corporate Secretary or equivalent, as to the truth and authenticity of the document is generally sufficient. B. Where audited financial statements or independent feasibility studies are required, the signed opinion of the preparer is generally sufficient. C. All other documents must be attested to by persons authorized by the charter or agreement of the applicant to make such affirmations. D. Where signatures are required, only an original manual signature is acceptable. Facsimiles are not acceptable and applications or reports so signed will be returned to you.

V. **CONTRACTS, DOCUMENTS OR AGREEMENTS:** A. All contracts, documents, or agreements, etc. required by Chapter 651, FS, or any rule promulgated pursuant thereto must be filed with (in duplicate with this application) and approved by the Office prior to its use in this state. Any document received must have on the first page a unique identifier or it will be returned as unacceptable for filing. For consistency, we recommend you utilize the following abbreviations as unique identifiers: RC - Residency Contract; RESV C - Reservation Contract; EA - Escrow Agreement; DSR – Debt Service Reserve; OR – Operating Reserve; RRR or R3 – Renewal and Replacement Reserve; Br Ad - Broadcast Advertisement; and Pr Ad - Printed Advertisement.. An example is as follows: A residency contract for Woodland Hills Retirement Center - 88999, who holds a PCOA: 88999RC07/19/97. No. 88999 identifies the submitter as Woodland Hills Retirement Center. RC identifies the document as a residency contract, and 07/19/97 identifies the date the document was drafted and submitted for approval. Any documents used in the normal course of business such as advertising, escrow agreements, reservation contracts, residency contracts, pamphlets, etc., must contain the unique identifier. B. Each material change, addendum, amendment or alteration of any service or information in a previously approved form constitutes a new form and must be filed with and approved by the Office prior to its use. New forms as outlined above and submitted for approval should be accompanied by a copy containing the changes, addendum, amendment or alteration underlined in red or "redlined."

VI. ADVERTISING: All prospective advertising must be submitted and approved by the Office prior to issuance and while holding the PCOA unless instructed otherwise. After issuance of a certificate of authority (COA), the advertising is not required to be submitted to the Office. The provider will remain responsible, however, for its advertising's content and use pursuant to Section 651.095, FS and Rules 69O-193.038, 4-193.040 and 4-193.043, FAC, and all rules promulgated thereunder and for maintaining its file. All advertising must be maintained on file for three years.

VII. FEASIBILITY STUDIES - PHASED DEVELOPMENTS: A. Each applicant for a PCOA must submit a feasibility study that meets the requirements of Section 651.022(3), FS. Each applicant for COA must submit a feasibility study that meets the requirements of Section 651.023(1)(b), FS. B. If a phased development is employed in the construction of the facility, each phase must stand on its own merits. The feasibility study must clearly demonstrate that the phase for which you are seeking a PCOA or a COA, as well as the overall project, is feasible when completed. Any feasibility study failing to do so, will cause the application to be unacceptable.

VIII. REQUIRED REPORT FILING: A. Each "Provider" holding a PCOA must submit verification of compliance with their projections for unit sales per month within 25 days from each month's end. B. Each "Provider" holding a COA must submit the following documents and information on or before May 1 of each year or within 120 days of the end of the designated fiscal year and for the preceding year or portion thereof, regardless of whether the facility is operational or not: 1. A minimum liquid reserve calculation, form OIR-A3-477. 2. An annual report, form OIR-A3-470. The annual report must be completed and returned to this office together with a separately bound audited financial statement prepared in accordance with generally accepted accounting principles by an Independent Certified Public Accountant. 3. Where a "Provider" owns or operates more than one facility, a consolidated financial statement is acceptable for the entire corporate entity provided complete supplemental schedules are included for each licensed facility in this state. 4. If the "Provider" owns or operates more than one facility in this state and files consolidated audited financial statements for the entire corporate entity, they must also file a separate statement of operations for each licensed facility in the state. If the provider has operations that are not Florida certificated facilities, they must also file a separate balance sheet, statement of operations, changes in equity, and cash flows for each Florida facility as supplemental schedules to the audited financial statements. C. Unless otherwise specified by the Office, each certificate holder must submit periodic sales and financial reports, form OIR-A3-974, quarterly and within 45 days of the end of the designated period. D. All financial reports must be prepared on a calendar year basis except as otherwise provided in Section 651.026(5), FS. E. Each quarter, escrow statements from the escrow agent indicating the amount of any disbursements from or deposits to the various escrow accounts required by Chapter 651, FS, must be submitted to the Office pursuant to applicable statutes. Escrow statements, which detail how the funds in escrow have been invested must be confirmed by the provider that all funds investment in escrow meets the requirements of PART II of Chapter 625, FS.

IX. ACQUISITIONS AND MERGERS: PCOA and COA are non-transferable. In the event of an acquisition, merger or change in control, the acquiring entity must file an application under Section 628.4615, FS. Contact the Applications Coordination Section for an application form.

- X. PROCESSING AND REVIEW: The Office adheres to the requirements of Chapter 651, FS and all rules promulgated pursuant thereto. A. When fees are required in connection with an application, all checks should be made payable to: "Office of Insurance Regulation".
- B. Questions or inquiries may be directed to:

Office of Insurance Regulation
Bureau of Specialty Insurers
200 East Gaines Street, Larson Building
Tallahassee, Florida 32399-0331
(850) 413-3144

Applications will normally be processed within thirty (30) days from the date of receipt by the Applications Coordination Section.

**DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
APPLICATION FOR PROVISIONAL CERTIFICATE OF AUTHORITY TO PROVIDE
CONTINUING CARE IN THE STATE OF FLORIDA
EXHIBIT III-3
INTERROGATORIES**

1. The applicant is: _____

(Name)

(Address)

(City, State, Zip Code)

(Area Code, Telephone Number / Area Code, Fax Number)

(Federal Employers Identification Number)

2. The contact person for the applicant is:

(Name)

(Address)

(City, State, Zip Code)

(Area Code, Telephone Number / Area Code, Fax Number)

Please indicate whether or not you wish to have clarifications and communications regarding this application sent to you by internet and if so, what email address they should be sent to:

Yes No

(Email Address)

3. The facility when completed will be located at:

(Street Address)

(City, County, State, and Zip Code)

4. The facility will be known as: _____
5. When completed, the facility will contain:
 _____ independent CCRC living units, and
 _____ independent Rental Living units, for a total number of
 _____ independent units to be constructed.
6. When completed the facility will have: (check as applicable):
 _____ Assisted Living.
 _____ Intermediate Care.
 _____ Skilled Nursing Care.
7. Health care will be provided: (check one)
 _____ on-site
 _____ off-site _____ other (Provide Detailed Explanation).
8. Identify the entity that has or will actually make application for the proposed nursing bed "Certificate of Need" with the Florida Agency for Health Care Administration:

9. Enter the total number of sheltered skilled nursing beds proposed to be included in the project:
 _____. If both sheltered and community skilled nursing beds are proposed, explain:

CHECK THE FOLLOWING AS APPROPRIATE:

10. The applicant is the owner of the proposed facility site?
 _____ YES; _____ NO.
11. The applicant intends to operate the facility?
 _____ YES; _____ NO.
12. The applicant intends to manage the facility?
 _____ YES; _____ NO.

13. The applicant intends to employ a management company to operate the facility?

_____ YES; _____ NO.

(If yes submit a copy of the agreement in Section III-2, which must comply with Section 651.1151, FS, a list of the officers and directors of the management company and complete biographical information for all principals as detailed in Sections IV-2 through IV-4, Management.)

14. The applicant is a corporation for-profit.

_____ YES; _____ NO.

15. The applicant is a corporation not-for-profit.

_____ YES; _____ NO.

16. The applicant is a General Partnership.

_____ YES; _____ NO.

17. The applicant is a Limited Partnership.

_____ YES; _____ NO.

18. The applicant is a Limited Liability Company

_____ YES; _____ NO.

19. Has the applicant or any entity affiliated with or controlling the applicant ever been convicted of a felony or pled nolo contendere to a felony charge or held liable or enjoined in a civil action by final judgment, if such action involved fraud, embezzlement, fraudulent conversion, or misappropriation of property or are such actions currently pending?

_____ YES; _____ NO.

(If yes submit a certified copy of the complaint and the final adjudication by the recording public official.)

20. Is the applicant or any entity affiliated with or controlling the applicant currently the subject of an injunctive or restrictive order or federal or state administrative order relating to business activity or health care as a result of an action brought by a public agency or department, including, without limitation, an action affecting a license under Chapter 400, Florida Statutes?

_____ YES; _____ NO.

(If yes submit a certified copy of the complaint and the final adjudication by the recording public official.)

21. Has the applicant or any entity affiliated with or controlling the applicant, ever owned, operated, managed or developed a continuing care retirement community, adult congregate living facility or nursing home or similar facility?

_____ YES; _____ NO.

22. Is the applicant or any entity affiliated with or controlling the applicant currently, own, operate, manage or are they developing any continuing care facility in any state?

_____ YES; _____ NO.

23. State the name, business address, and title of the individual who prepared the feasibility study:

24. Furnish the page number(s) from the feasibility study where the following information can be found regarding the proposed facility:

- a. A description. pg _____
- b. The location. pg _____
- c. The size. pg _____
- d. The anticipated completion date. pg _____
- e. The proposed construction program. pg _____
- f. The primary market area. pg _____
- g. The secondary market area. pg _____
- h. Unit sales per month. pg _____
- i. Projected revenue & expense statements. pg _____
- j. Marketing expenses. pg _____
- k. Staffing requirements. pg _____
- l. Cost of property, plant & equipment. pg _____
- m. Projected balance sheet. pg _____

- n. Projected cash flow statements. pg _____
- o. Inflation factors. pg _____
- p. Estimate of funds required to cover start-up losses. pg _____
- q. Project costs. pg _____
- r. Marketing projections. pg _____
- s. Resident fees & charges. pg _____
- t. Competition. pg _____
- u. Contract provisions. pg _____
- v. Breakeven point. pg _____

25. For accounting and reporting purposes, the applicant's fiscal year-end will be:

**DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
MANAGEMENT INFORMATION FORM
COMPLETE LISTING OF INCORPORATORS, OFFICERS,
DIRECTORS, SHAREHOLDERS (10% OR MORE), PARTNERS, PROPRIETOR,
MANAGEMENT COMPANY PRINCIPALS, ASSOCIATION MEMBERS, AND TRUSTEES**

For All Individuals Listed Please Provide The Following Information: Name / Company(ies) / Title(s) / Residence / Bus. Address / and Ownership Percentage (if appropriate)

INCORPORATORS / OFFICERS / DIRECTORS / SHAREHOLDERS

PARTNERS / PROPRIETOR / MANAGEMENT COMPANY PRINCIPALS

ASSOCIATION MEMBERS / TRUSTEES

CERTIFICATION BY PREPARER

Signature, Position of Preparer and Date (See Section IV-1 For Details)

NOTE: THIS FORM AND METHOD OF PAYMENT FOR USE ONLY BY NON-U.S. CITIZENS WITH NO SOCIAL SECURITY NUMBER – ALL OTHER APPLICANTS SEE OIR-C1-938 FOR FINGERPRINT PROCESSING PAYMENT INSTRUCTIONS



OFFICE OF INSURANCE REGULATION
Company Admissions

INVOICE FOR NON-U.S. CITIZENS WITH NO SOCIAL SECURITY NUMBER

REQUEST FOR PAYMENT OF FINGERPRINT CHARGES

NAME OF COMPANY: _____

FEIN: _____

ADDRESS: _____

_____ CITY STATE ZIP CODE

ADDRESS (IF DIFFERENT FROM COMPANY ADDRESS)

_____ CITY STATE ZIP CODE

In reference to the recent submission by the above referenced insurer regarding the fingerprint cards requested on each officer and/or director, it is necessary that this form and the fingerprint cards be returned with the proper payment as listed below for the processing of these cards.

PLEASE NOTE:

1. Send a check in the proper amount payable to the Florida Department of Financial Services and **mail check and invoice only** to the Department of Financial Services, Bureau of Financial Services, Post Office Box 6100, Tallahassee, Florida 32314-6100.
2. Send fingerprint cards, a **copy** of the check and invoice along with the completed application package to the Florida Office of Insurance Regulation, Company Admissions, Larson Building, 200 East Gaines Street, Tallahassee, Florida 32399-0332.

B/T
C

TY/CL
1002

F/T
F

FEE SCHEDULE:

Number of Cards _____ @ \$64.00 per person ... \$ _____

Attach list of individuals for whom fingerprint cards are submitted with this invoice.



OFFICE OF INSURANCE REGULATION
Company Admissions

INSTRUCTIONS FOR FURNISHING BACKGROUND INVESTIGATIVE REPORTS

1. A background investigative report must be completed for each individual as indicated in the instructions in the application package.
2. Please refer to the NAIC website at http://www.naic.org/industry_ucaa.htm, "Third Party Vendors for Background Reports", for specific information regarding background investigation vendors.
3. The applicant is responsible for paying for the reports and for handling billing arrangements with the selected vendor.
4. Applicants are required to ensure that the selected vendor will transmit investigative reports electronically to the Florida Office of Insurance Regulation ("Office") to this e-mail address: bkgrnd-inv@flor.com in Microsoft Word format, with appropriate reference to the applicant in the subject of each transmittal e-mail.
5. Applicants are required to arrange for the reports to be directly transmitted to the Office by the selected vendor to this e-mail address: bkgrnd-inv@flor.com prior to or contemporaneously with the submission of each application filing, with the exception of acquisition filings.
6. Acquisition filings must include evidence indicating that background reports have been ordered, including proof of payment.
7. Any questions regarding this process may be directed to the Office at appcoord@flor.com



Office of Insurance Regulation Company Admissions

FINGERPRINT CARD AND PAYMENT INSTRUCTIONS

For instructions on payment of fingerprint processing fees, and for using the digital fingerprint option, see Page 2.

Fingerprints submitted on a card not provided by the Florida Office of Insurance Regulation will not be accepted.

THE CARD MUST BE SIGNED BY THE APPLICANT.

FLORIDA RESIDENTS: You must take the fingerprint card to a law enforcement agency in Florida for fingerprint service.

OUT OF STATE RESIDENTS: CONSULT YOUR LOCAL LAW ENFORCEMENT AGENCIES FOR ADDITIONAL INSTRUCTIONS.

The top portion of the fingerprint card must be completed in order for FDLE and FBI to process the card. If the law enforcement agency does not fill out the top portion of the card for you, you are responsible for filling it out with all information applicable to you.

The following specific instructions should be followed:

- ◆ Fingers should be washed and dried thoroughly prior to prints being taken.
- ◆ Do not sign the fingerprint card until you are in the presence of the person who will take the fingerprints.
- ◆ The fingerprint card **MUST** be typed or filled out in **BLACK INK**.
- ◆ Your name, at the top of the fingerprint card, and all other information should be typed or printed clearly.
- ◆ Identity of private contractors should be shown in space "EMPLOYER AND ADDRESS".
- ◆ The section titled Date of Birth DOB, Place of Birth POB, SEX, HGT (height), WGT, (weight), EYES, and HAIR must all be filled out.

RACE- Use W for White, B for Black, A for Asian, I for Indian, etc. DO NOT USE THE LETTER C.

HGT- Use feet and Inches. DO NOT USE TOTAL INCHES.

EYES AND HAIR- To describe color of eyes and hair, use appropriate three letter code from the following list:

<u>COLOR</u>	<u>CODE</u>	
Bald**	BAL	(Hair Only)
Black	BLK	(Hair Only)
Blond or Strawberry	BLN	(Hair Only)
Blue	BLU	(Eyes Only)
Brown	BRO	
Gray or Partially Gray	GRY	(Hair Only)
Green	GRN	(Eyes Only)
Hazel	HAZ	(Eyes Only)
Red or Auburn	RED	(Hair Only)
White	WHI	(Hair Only)

- ◆ **Bald (BAL) is to be used when the subject has lost most of the hair on top of their head.
- ◆ The section titled Citizenship CTZ is for your citizenship –USA, Cuba, Canada, etc.
- ◆ The section titled Armed Forces No. MNU is for your military service number if you have one.
- ◆ The section titled Social Security No. SOC is for your social security number if you have one, and it is VERY IMPORTANT. However, pursuant to section 119.072, Florida Statutes, the social security number must be collected and maintained on a separate page, see attached.
- ◆ You are not required to fill out the sections titled:

Your No. OCA
 FBI No. FBI
 Miscellaneous No. MNU

Do not fold or damage the fingerprint card in any way. The fingerprint card cannot be processed if it has been folded, erased or damaged. You may include cardboard backing to protect the fingerprint card if you like.

NOTICE: Your fingerprint card must be typed or filled out in BLACK INK. Information which has been entered on the cards may not be altered in any way, i.e., erased, covered with correction fluid or tape, marked out, etc. In addition, cards may not be folded, stapled, torn or marred in any way.

FINGERPRINT PAYMENT AND LIVESCAN INSTRUCTIONS

When submitting paper fingerprint cards:

1. Pre-payment of fingerprint processing fees shall be made electronically at www.fldfsprints.com

Step 1: Begin Registration.
Step 2: Enter Your CRI: FL921400Z – OIR – INSURANCE COMPANY OFFICER/DIRECTOR.
Step 3: Pay for Ink Card Submission.
Step 4: Enter Personal Information.

2. Submit a copy of the on-line payment confirmation along with the completed cards and other filing documents to Florida Office of Insurance Regulation, Company Admissions Section, 200 E. Gaines Street, Tallahassee, FL 32399-0332.

When using the LiveScan Option (Florida residents only):

1. Pre-payment of fingerprint processing fees for LiveScan submissions shall be made electronically at www.fldfsprints.com.

Step 1: Begin Registration.
Step 2: Enter Your CRI: FL921400Z – OIR – INSURANCE COMPANY OFFICER/DIRECTOR
Step 3: Enter a zip code to determine the closest fingerprinting location **or** choose the region you will be in for your identification appointment.
Step 4: Enter Personal Information.

2. Submit a copy of the on-line payment confirmation along with other filing documents to Florida Office of Insurance Regulation, Company Admissions Section, 200 E. Gaines Street, Tallahassee, FL 32399-0332.

Individuals who are non-U.S. citizens with no social security number should continue to submit payment of fingerprint fees per instructions in form OIR-C1-903.

For questions email appcoord@flor.com.

CONFIDENTIAL

Pursuant to sections 119.071(5), Florida Statutes, social security numbers collected by an agency are confidential and exempt from section 119.07, Florida Statutes, and section 24(a), Art. I of the State Constitution. The requirement must be relevant to the purpose for which collected and must be clearly documented. The social security numbers must be segregated on a separate page from the rest of the record.

Applicant's Name: _____

Applicant's Social Security Number: _____

The requirement for the applicant's social security is mandatory.

Section 119.071(5), Florida Statutes, gives authority for an agency to collect social security numbers if imperative for the performance of that agency's duties and responsibilities as prescribed by law. Limited collection of social security numbers is imperative for the Office of Insurance Regulation. The duties of the Office of Insurance Regulation in background investigation are extensive in order to insure that the owners, management, officers, and directors of any insurer are competent and trustworthy, possess financial standing and business experience, and have not been found guilty of, or not pleaded guilty or nolo contendere to, any felony or crime punishable by imprisonment of one year. In establishing these qualifications and the Office of Insurance Regulation's responsibility to ensure that individuals meet these qualifications, the legislature recognized that owners, officers, and directors of an insurance company are in a position to cause great harm to public should they be untrustworthy or have a criminal background. These individuals control vast amount of funds that belong to policyholders. To meet the legislative intent that these people are qualified to be trusted, having the identifying social security number is essential for the Office of Insurance Regulation to adequately perform the background investigative duty. There are many individuals with the same name, without this identifying number it would be difficult if not impossible to be reasonably sure that the correct individuals are identified and verify they meet the statutorily required conditions.

CONFIDENTIAL



OFFICE OF INSURANCE REGULATION

Company Admissions

Applicant Name (Company) _____

NAIC No. _____

FEIN: _____

BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority.

(Print or Type)

Full Name, Address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names). _____

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. Affiant's Full Name (Initials Not Acceptable). _____

2. a. Are you a citizen of the United States?

b. Are you a citizen of any other country, if so, what country? _____

3. Affiant's Occupation or Profession. _____

4. Affiant's business address. _____

Business telephone. _____

5. Education and Training:

<u>College/ University</u>	<u>City/ State</u>	<u>Dates Attended (MM/YY)</u>	<u>Degree Obtained</u>
_____	_____	_____	_____

<u>Graduate Studies:</u>	<u>College/ University</u>	<u>City/ State</u>	<u>Dates Attended (MM/YY)</u>	<u>Degree Obtained</u>
_____	_____	_____	_____	_____

<u>Other Training: Name</u>	<u>City/ State</u>	<u>Dates Attended (MM/YY)</u>	<u>Degree/Certification Obtained</u>
_____	_____	_____	_____

(Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number in the space provided in the Biographical Affidavit Supplemental Information.)

Applicant Name (Company) _____

NAIC No. _____
FEIN: _____

6. List of memberships in professional societies and associations.

<u>Name of Society/Association</u>	<u>Contact Name</u>	<u>Address of Society/Association</u>	<u>Telephone Number of Society/Association</u>

7. Present or proposed position with the applicant entity. _____

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years.

Beginning/Ending
Dates (MM/YY) _____ - _____ Employer's Name _____

Address _____ City _____ State/Province _____

Country _____ Postal Code _____ Phone _____ Offices/Positions Held _____

Supervisor / Contact _____

Beginning/Ending
Dates (MM/YY) _____ - _____ Employer's Name _____

Address _____ City _____ State/Province _____

Country _____ Postal Code _____ Phone _____ Offices/Positions Held _____

Supervisor / Contact _____

Beginning/Ending
Dates (MM/YY) _____ - _____ Employer's Name _____

Address _____ City _____ State/Province _____

Country _____ Postal Code _____ Phone _____ Offices/Positions Held _____

Supervisor / Contact _____

Beginning/Ending
Dates (MM/YY) _____ - _____ Employer's Name _____

Address _____ City _____ State/Province _____

Country _____ Postal Code _____ Phone _____ Offices/Positions Held _____

Applicant Name (Company) _____

NAIC No. _____

FEIN: _____

Supervisor / Contact _____

9. a. Have you ever been in a position which required a fidelity bond? _____ If any claims were made on the bond, give details. _____

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked? If yes, give details. _____

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license (s) issued.. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, "SSN", "12-SSN-345" or "1234-SSN" (last 6 digits)). Attach additional pages if the space provided is insufficient

Organization/Issuer of License _____ Address _____

City _____ State/Province _____ Country _____ Postal Code _____

License Type _____ License # _____ Date Issued (MM/YY) _____

Date Expired (MM/YY) _____ Reason for Termination _____

Non-insurance Regulatory Phone Number (if known) _____

Organization /Issuer of License _____ Address _____

City _____ State/Province _____ Country _____ Postal Code _____

License Type _____ License # _____ Date Issued (MM/YY) _____

Date Expired (MM/YY) _____ Reason for Termination _____

Non-insurance Regulatory Phone Number (if known) _____

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:

a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency? _____

b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action? _____

c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action? _____

- d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses? _____
- e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?

- f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses? _____
- g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking? _____
- h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute? _____
- i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government? _____
- j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?

If the response to any question above is answered "Yes", please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

- 12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. _____

If any of the stock is pledged or hypothecated in any way, give details. _____

- 13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified. If the answer is "Yes", please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

If any of the shares of stock are pledged or hypothecated in any way, give details.

Applicant Name (Company) _____

NAIC No. _____

FEIN: _____

14. Have you ever been adjudged a bankrupt? _____ If yes, provide details _____

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity? If yes, please indicate and give details. When responding to questions (b) and (c) affiant should also include any events within twelve (12) months after his or her departure from the entity.

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or Governmental-licensing agency? _____

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)? _____

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action? _____

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this _____ day of _____ 20__ at _____ I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

(Signature of Affiant)

State of _____ County of _____

The foregoing instrument was acknowledged before me this _____ day of _____, 20____ By

_____, and:

who is personally known to me, or

who produced the following identification: _____

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires



OFFICE OF INSURANCE REGULATION
Company Admissions

Applicant Name (Company) _____

NAIC No. _____
FEIN: _____

BIOGRAPHICAL AFFIDAVIT
Supplemental Personal Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority.

Full Name, Address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

1. Affiant's Full Name (Initials Not Acceptable). _____
2. Have you ever used any other name including nickname, maiden name or aliases? ____ If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

<u>Beginning/Ending</u> <u>Date(s) Used (MM/YY)</u>	<u>Name(s)</u>	<u>Reason (If None, indicate such)</u>
_____-_____-	_____	_____
_____-_____-	_____	_____
_____-_____-	_____	_____
_____-_____-	_____	_____
_____-_____-	_____	_____
_____-_____-	_____	_____
_____-_____-	_____	_____
_____-_____-	_____	_____
_____-_____-	_____	_____
_____-_____-	_____	_____

Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another.

3. Affiant's Social Security Number _____
4. Government Identification Number if not a U.S. Citizen _____

Applicant Name (Company) _____

NAIC No. _____
FEIN: _____

5. Foreign Student ID# (if applicable) _____

6. Date of Birth: (MM/DD/YY) _____ Place of Birth: City _____
State/Province _____ Country _____

7 Name of Affiant's Spouse (if applicable) _____

8. List your residences for the last ten (10) years starting with your current address, giving:

Beginning/Ending

Dates (MM/YY)	Address	City	State/ Province	Country	Postal Code
------------------	---------	------	--------------------	---------	-------------

Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this _____ day of _____, 20____ at _____ I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

(Signature of Affiant)

State of _____ County of _____

The foregoing instrument was acknowledged before me this _____ day of _____, 20____ By _____, and:

- who is personally known to me, or
- who produced the following identification: _____

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

Applicant Name (Company) _____

NAIC No. _____

FEIN: _____

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS (*All states except California, Minnesota and Oklahoma*)

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of _____ **[insert company name]** (“Company”) for licensure or a permit to organize (“Application”) with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) (“Background Reports”) regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative (“Affiant”) of Company or of any business entities affiliated with Company (“Term of Affiliation”) for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency (“CRA”) that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact _____ **[insert company’s designated person, position, or department, address and phone]**.

Attached for your information is a “Summary of Your Rights Under the Fair Credit Reporting Act.”

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) twelve (12) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

(Printed Full Name and Residence Address)

(Signature)

(Date)

State of _____ County of _____

The foregoing instrument was acknowledged before me this _____ day of _____ 20____ By _____, and

- who is personally known to me, or
- who produced the following identification: _____

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

Applicant Name (Company) _____

NAIC No. _____

FEIN: _____

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS (Minnesota and Oklahoma)

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of _____ **[insert company name]** ("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) ("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may request more information about the nature and scope of Background Reports produced by any consumer reporting agency ("CRA") by submitting a written request to Company. You should submit any such written request for more information, to _____ **[insert company's designated person, position, or department, address and phone]**.

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act." You will be provided with a copy of any Background Report procured by Company if you check the box below.

By checking this box, I request a copy of any Background Report from any CRA retained by Company, at no extra charge.

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) twelve (12) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

(Printed Full Name and Residence Address)

(Signature)

(Date)

State of _____ County of _____

The foregoing instrument was acknowledged before me this _____ day of _____, 20_____. By _____, and

who is personally known to me, or

who produced the following identification: _____

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

Applicant Name (Company) _____

NAIC No. _____

FEIN: _____

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS (California)

This Disclosure and Authorization is provided to you in connection with a pending application of _____ **[insert company name]** (“Company”) for licensure or a permit to organize (“Application”) with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) (“Background Reports”) regarding your background for review by any department of insurance in such states where Company is currently pursuing an Application, because you are either functioning as, or are seeking to function as, an officer, member of the board of directors or other management representative (“Affiant”) of Company or of any business entities affiliated with Company (“Term of Affiliation”) for which a Background Report is required by a department of insurance reviewing any Application. Background Reports will be obtained through _____ **[insert name of CRA, address]** (“CRA”). Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may request more information about the nature and scope of Background Reports produced by any consumer reporting agency (“CRA”) by submitting a written request to Company. You should submit any such written request for more information, to _____ **[insert company’s designated person, position, or department, address and phone]**.

Attached for your information is a “Summary of Your Rights Under the Fair Credit Reporting Act.” You will be provided with a copy of any Background Report procured by Company if you check the box below.

By checking this box, I request a copy of any Background Report from any CRA retained by Company, at no extra charge.

Under section 1786.22 of the California Civil Code, you may view the file maintained on you by the CRA listed above. You may also obtain a copy of this file, upon submitting proper identification and paying the costs of duplication services, by appearing at the CRA in person or by mail; you may also receive a summary of the file by telephone. The CRA is required to have personnel available to explain your file to you and the CRA must explain to you any coded information appearing in your file. If you appear in person, you may be accompanied by one other person of your choosing, provided that person furnishes proper identification.

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. In no event, however, will this authorization remain in effect beyond twelve (12) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

(Printed Full Name and Residence Address)

(Signature)

(Date)

State of _____ County of _____

The foregoing instrument was acknowledged before me this _____ day of _____, 20____ By _____, and

- who is personally known to me, or
- who produced the following identification: _____

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires