



**OFFICE OF INSURANCE REGULATION**

***Company Admissions***

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
MEDICARE PLUS CHOICE PROVIDER SPONSORED ORGANIZATIONS (PSO)**

The Medicare Plus Choice Provider Sponsored Organization's Application for Certificate of Authority requires five (5) categories of information:

Section I	Application Fees and Form
Section II	Legal
Section III	Financial and Related Information
Section IV	Management
Section V	Forms and Rates

It is important to complete each section in the specified format without omitting any requested information.

Please submit your package in a tabbed binder. (Example: the tab labeled II-1 would contain the certified Articles of Incorporation and all amendments).

Submit the completed application package to:

Office of Insurance Regulation  
Company Admissions  
200 East Gaines Street,  
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.**

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
MEDICARE PLUS CHOICE PROVIDER SPONSORED ORGANIZATIONS (PSO)**

In order to qualify as a Medicare Plus Choice Provider Sponsored Organization, an entity must:

- A. Be a public or private entity;
- B. Be established, or organized and operated, by a health care provider or group of affiliated health care providers;
- C. Provide a substantial proportion of the health care items and services (pursuant to the Medicare Plus Choice program) directly through the provider or affiliated group of providers; and affiliated providers share, directly or indirectly, substantial financial risk for the provision of such items and services and have at least a majority financial interest in the entity.
- D. Be a participant in the Federal Medicare Plus Choice program.
- E. Only cover Medicare Plus Choice recipients.

Although a pre-filing conference is not a statutory requirement, it has proven beneficial to both the applicant and the Office of Insurance Regulation. To schedule a conference, please call the Applications Coordination Section, (850) 413-2570.

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
MEDICARE PLUS CHOICE PROVIDER SPONSORED ORGANIZATIONS (PSO)**

**INSTRUCTIONS**

**SECTION I - APPLICATION FEES AND FORM**

**Section I-1            Application Fee**

The application filing fee is \$1,000.

Secure the check to the invoice, which is 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 the 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 Certificate of Authority (Official Form Attached)**

An original signature by the president or chief executive officer and one other authorized officer must appear on the application form under corporate seal.

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
MEDICARE PLUS CHOICE PROVIDER SPONSORED ORGANIZATIONS (PSO)**

**SECTION II - LEGAL**

**Section II-1           Articles of Incorporation**

Include in this section the applicant's Articles of Incorporation and all amendments. The required filings must be recently certified by the official public records custodian in the applicant's state of domicile. The certification letter must be an original.

**Section II-2           Certificate of Status from Florida Secretary of State**

If the entity is incorporated, submit an original certificate of status by the Florida Secretary of State's office demonstrating that the company is in good standing.

**Section II-3           Company Bylaws**

Include a copy of the corporation's By-Laws, Constitution, and/or Rules and Regulations in this section. The bylaws must be sealed, signed and dated by the Secretary of the company. No signatures other than the Secretary's will be accepted. The Secretary's statement must also be recently dated.

**Section II-4           Health Care Provider Certificate**

Submit documentation demonstrating that the entity has filed an application for a Health Care Provider Certificate to be issued by the Agency for Health Care Administration (AHCA). Documentation may be provided in the form of an acknowledgement from the Agency for Health Care that they have received the application.

NOTE: The Office of Insurance Regulation will begin its review of an application for a Certificate of Authority any time after an organization has filed an application for the certificate with the Agency for Health Care Administration. The Office of Insurance Regulation shall not issue a Certificate of Authority to any applicant which does not possess a valid Health Care Provider Certificate. Once the Health Care Provider Certificate is issued, a copy must be provided to the Office of Insurance Regulation.

**Section II-5           Authorization Letter**

A letter of Authorization is required for anyone other than company personnel or the company sponsoring agent, designating the named individual to represent the applicant.

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
MEDICARE PLUS CHOICE PROVIDER SPONSORED ORGANIZATIONS (PSO)**

**Section II-6 Medicare Plus Choice Contract**

Prior to commencing operations, the Medicare Plus Choice Provider Sponsored Organization must provide the Office of Insurance Regulation with a copy of its Medicare Plus Choice contract with the Health Care Financing Administration (HCFA).

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
MEDICARE PLUS CHOICE PROVIDER SPONSORED ORGANIZATIONS (PSO)**

**SECTION III - FINANCIAL AND RELATED INFORMATION**

**Section III-1            Financial Requirements**

A. Provide a copy of the most recent audited certified public accountant's report, if applicable. If the applicant is a development stage company that has not begun operations, an audited balance sheet should be provided. The financial statements should reflect sufficient surplus to meet the following requirements:

(1) Initial Net Worth

Minimum net worth amount: \$1.5 million, unless documentation is provided from HCFA authorizing a reduced minimum net worth of \$1 million.

Amount to be met by cash or cash equivalents: \$750,000.

(2) Continuing Net Worth Requirements

A minimum net worth amount equal to the greater of:

- a) One million dollars;
- b) Two percent of annual premium revenues as reported on the most recent annual financial statement filed with the Office of Insurance Regulation for up to and including the first \$150,000,000 of annual premiums and 1 percent of annual premium revenues on premiums in excess of \$150,000,000;
- c) An amount equal to the sum of three months of uncovered health care expenditures as reported on the most recent financial statement filed with the Office of Insurance Regulation; or
- d) Using the most recent annual financial statement filed with the Office of Insurance Regulation, an amount equal to the sum of:
  - Eight percent of annual health care expenditures paid on a non-capitated basis to non-affiliated providers; and
  - Four percent of annual health care expenditures paid on a capitated basis to non-affiliated providers plus annual health-care expenditures paid on a non-capitated basis to affiliated providers.

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
MEDICARE PLUS CHOICE PROVIDER SPONSORED ORGANIZATIONS (PSO)**

- Annual health care expenditures that are paid on a capitated basis to affiliated providers are not included in the calculation of the net worth requirement.

Amount to be met by cash or cash equivalents: The greater of \$750,000 or 40 percent of the minimum net worth amount.

**B. Components of Net Worth**

**(1) Health Care Delivery Assets:**

Admit 100% of book value (GAAP depreciated value) of Health Care Delivery Assets on the balance sheet of the Medicare Plus Choice PSO.

Health Care Delivery Assets include any tangible asset that are part of the Medicare Plus Choice PSO operation, including: hospitals, medical facilities, and their ancillary equipment, and such property as may reasonably be required for the entity's principal office or for such purposes as may be necessary in the transaction of business.

**(2) Intangible Assets:**

**Initial Calculation**

- a) If at least \$1 million of the initial minimum net worth requirement is met by cash or cash equivalents, then the GAAP value of intangible assets will be admitted up to 20% of the initial minimum net worth amount required.
- b) If less than \$1 million of the initial minimum net worth requirement is met by cash or cash equivalents or is reduced to an initial net worth requirement below \$1.5 million, then the GAAP value of intangible assets will be admitted up to 10% of the minimum initial net worth amount required.

**Ongoing Calculation**

- a) Up to 20 percent of the minimum net worth amount will be admitted if the greater of \$1,000,000 or 67 percent of the minimum net worth amount is met by cash or cash equivalents; or
- b) Up to ten percent of the minimum net worth amount will be admitted if the greater of \$1,000,000 or 67 percent of the minimum net worth amount is not met by cash or cash equivalents.

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
MEDICARE PLUS CHOICE PROVIDER SPONSORED ORGANIZATIONS (PSO)**

- (3) Subordinated Debts and Subordinated Liabilities.

Fully subordinated debt and subordinated liabilities are excluded from the calculation of an entity's net worth for purposes of meeting the minimum requirements.

- (4) Deferred acquisition costs are not admitted.

- (5) Calculation--other assets:

Other assets not used in the delivery of health care may be used for purposes of meeting the minimum net worth requirement, provided such assets are reported using Florida Statutory accounting practices.

C. Liquidity

- (1) A Medicare Plus Choice PSO must demonstrate sufficient cash flow to meet financial obligations as they become due and payable.
- (2) The Medicare Plus Choice PSO should demonstrate the methods to be utilized in meeting its cash flow obligations in the Plan's projected financial statements.
- (3) To determine whether the Medicare Plus Choice PSO continues to meet the requirement in paragraph (1) of this section, the Office will examine the following:
- a) The Medicare Plus Choice PSO's timeliness in meeting current obligations;
  - b) The extent to which the Medicare Plus Choice PSO's current ratio of assets to liabilities is maintained at 1:1 including whether there is a declining trend in the current ratio over time; and
  - c) The availability of outside financial resources to the Medicare Plus Choice PSO.
- (4) If a Medicare Plus Choice PSO fails to meet the requirements in paragraph (3)(a) of this section, the Office will require the Medicare Plus Choice PSO to initiate corrective action and pay all overdue obligations.

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
MEDICARE PLUS CHOICE PROVIDER SPONSORED ORGANIZATIONS (PSO)**

- (5) If a Medicare Plus Choice PSO fails to meet the requirement of paragraph (3)(b) of this section, the PSO will be required to initiate corrective action as follows:
- a) Change the distribution of its assets;
  - b) Reduce its liabilities; or
  - c) Make alternative arrangements to secure additional funding to restore the Medicare Plus Choice PSO's current ratio to 1:1.
- (6) If a Medicare Plus Choice PSO fails to meet the requirement of paragraph (3)(c) of this section, the Medicare Plus Choice PSO will be required to obtain funding from alternative financial resources.

**Section III-2          Financial Plan**

A.    Plan Content and Coverage:

At the time of application, the PSO must submit a financial plan demonstrating it has the resources available to cover the period through twelve-months **beyond** the projected break-even point.

A financial plan must include--

- A detailed marketing plan;
- Statements of revenue and expense on an accrual basis;
- A cash flow statement;
- Balance sheets;
- The assumptions in support of the financial plan;
- Availability of financial resources to meet projected losses.

Except for the use of guarantees as provided in section (1) below, and letters of credit as provided in section (2) below, the resources to meet projected losses must be assets on the balance sheet of the Medicare Plus Choice PSO in a form

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
MEDICARE PLUS CHOICE PROVIDER SPONSORED ORGANIZATIONS (PSO)**

that is either cash or will be convertible to cash in a timely manner, pursuant to the financial plan.

- (1) Guarantees will be accepted as a resource to meet projected losses, under the following conditions:

In the first year, the guarantor must provide the Medicare Plus Choice PSO with cash or cash equivalents to fund the projected losses, as follows:

- prior to the beginning of the first quarter, in the amount of the projected losses for the first two quarters;
- prior to the beginning of the second quarter, such that the Medicare Plus Choice PSO has cash or cash equivalents sufficient to meet projected losses through the end of the third quarter; and
- prior to the beginning of the third quarter, such that the Medicare Plus Choice PSO has cash or cash equivalents sufficient to meet the projected losses through the end of the fourth quarter.

- (2) An irrevocable, clean, unconditional letter of credit may be used in place of cash or cash equivalents if deemed satisfactory to the Office of Insurance Regulation.

The financial plan must be satisfactory to the Office of Insurance Regulation. At its discretion, the Office may require the financial plan to be certified by reputable and qualified actuary.

**B. Statement of Initial Cash**

Submit a statement of the proposed initial cash and cash reserves summary, including loan receipts, loan repayments, stock sales, etc. Also, describe the sources and terms of the funding. In the case of guaranteeing organizations, audited financial statements should be submitted for these entities.

**C. Deposit**

Each Medicare Plus Choice Provider Sponsored Organization shall deposit with the Office of Insurance Regulation cash or securities of the type eligible under s. 625.52, which shall have at all times a market value in the amount set forth in this subsection. The amount of the deposit shall be reviewed annually, or more often, as the department deems necessary. The market value of the deposit shall be a minimum of \$300,000, up to a maximum of \$2 million.

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
MEDICARE PLUS CHOICE PROVIDER SPONSORED ORGANIZATIONS (PSO)**

**Section III-3            Insurance**

- A.     Furnish evidence of adequate insurance coverage or an adequate plan for self-insurance to respond to claims for injuries arising from the provision of health care services. If not self-insured, submit executed copies of the following policies, with the Office of Insurance Regulation listed on the policies for purposes of notification of any modification, cancellation or termination of the policies:
- (1)    General liability.
- (2)    Medical malpractice or professional liability. The Medicare Plus Choice PSO must secure this coverage. The fact that the medical provider has this coverage does not release the Medicare Plus Choice PSO from the obligation to secure it. A binder for the policies along with a specimen copy of each policy can be submitted initially. Prior to licensure, executed copies of the policies must be submitted.
- B.     Furnish a photocopy of an executed fidelity bond in the minimum amount of \$100,000, issued by an **authorized insurance carrier** in this State and covering all employees handling funds.
- C.     Describe how the Medicare Plus Choice PSO limits or proposes to limit its financial risk. If the Medicare Plus Choice PSO secures catastrophic or reinsurance coverage, it is required to submit executed copies of the applicable policy with the Office of Insurance Regulation endorsed on the agreement as an additional insured. Each reinsurance agreement and any modifications thereto must be filed with and approved by the Office. Each such agreement must remain in full force and effect until replaced or for at least 90 days following written notification to the Office by registered mail of cancellation by either party.

**NOTE:**     Describe any risk sharing arrangements with providers or any other parties. Reference by application page number, the application sections of any provider contracts which demonstrate the sharing of risk between the Medicare Plus Choice PSO and providers.

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
MEDICARE PLUS CHOICE PROVIDER SPONSORED ORGANIZATIONS (PSO)**

**Section III-4            Contracts**

- A.     A copy of each type of contract made, or to be made, between the applicant and any providers (i.e. hospitals, physicians, physician groups) regarding the provision of health care services to enrollees.
  
- B.     A copy of the form of any contract made or to be made between the applicant and senior management employment, as well as any person, corporation, partnership, or other entity for the performance on the applicant's behalf of any function including, but not limited to, marketing, administration, enrollment, investment management, and subcontracting for the provision of health care services to enrollees.

**Section III-5            Grievance Procedure**

Grievances, Coverage Determinations, Reconsiderations and Appeals--As under current law, Medicare Plus Choice plans must maintain meaningful procedures for hearing and resolving grievances.

Medicare Plus Choice plans must have a procedure for making determinations regarding whether an enrollee is entitled to receive services and the amount the individual is required to pay for such services. Determinations must be made on a timely basis. The explanation of a plan's determination must be in writing and must explain the reasons for the denial in understandable language and describe the reconsideration and appeals processes. The time period for reconsiderations would be specified by the Secretary but could not be greater than 60 days after the request by the enrollee. Reconsiderations of coverage determinations to deny coverage based on lack of medical necessity must be made by a physician with expertise in the field of medicine which relates to the condition necessitating treatment.

Plans would be required to have an expedited review process in cases where the normal time frame for making a determination or reconsideration could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. Either the beneficiary or the physician could request an expedited review. Requests for expedited reviews made by physicians (even those not affiliated with the organization) must be granted by the plan. Expedited determinations and reconsiderations must be made within time periods specified by the Secretary, but not later than 72 hours after the request for expedited review, or such longer period as the Secretary may permit in specified cases.

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
MEDICARE PLUS CHOICE PROVIDER SPONSORED ORGANIZATIONS (PSO)**

The Secretary would be required to contract with an independent, outside entity to review and resolve plan reconsideration's not favorable to the beneficiary. If the independent review is unfavorable to the beneficiary, the beneficiary would have right to the same appeal process (e.g. ALJ, judicial review) as under existing HMO procedures.

**Section III-6            Bankruptcy Proceedings**

The following documentation must be provided:

- A.     An acknowledgment that a delinquency proceeding pursuant to Part I of Chapter 631 or supervision by the Office of Insurance Regulation pursuant to s. 624.80-624.87, Florida Statutes, constitutes the sole and exclusive method for the liquidation, rehabilitation, reorganization, or conservation of a Medicare Plus Choice Provider Sponsored Organization.
  
- B.     A waiver of any right to file or be subject to a bankruptcy proceeding; and
  
- C.     An acknowledgment that the commencement of a bankruptcy proceeding either by or against a Medicare Plus Choice Provider Sponsored Organization shall, by operation of law, terminate the Medicare Plus Choice PSO's certificate of authority and vest in the Office for the use and benefit of the subscribers of the Medicare Plus Choice Provider Sponsored Organization the title to any deposits of the insurer held by the Office.

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
MEDICARE PLUS CHOICE PROVIDER SPONSORED ORGANIZATIONS (PSO)**

**SECTION IV - MANAGEMENT**

**NAMES REQUESTED IN THIS SECTION SHOULD INCLUDE COMPLETE FIRST, MIDDLE AND LAST NAMES.**

**Section IV-1           List of All Officers, Directors and Stockholders**

- A. List the names, addresses and official positions of each officer, director and person having direct or indirect control of the organization, including but not limited to contracted management company personnel (form enclosed).
- B. List the names of each stockholder owning five percent or more of voting securities of the applicant or having the right to acquire in excess of ten percent of the voting securities of the applicant (issued and outstanding warrants/options, etc.). Such persons shall fully disclose to the Office and to the directors the extent and nature of any contracts or arrangements between them and the Medicare Plus Choice PSO, including any possible conflicts of interest.
- C. If the applicant is a subsidiary of a parent or holding company, provide an organizational chart showing the relationship of all related companies.

**Section IV-2           Biographical Statement and Affidavits for Officers, Directors and Stockholders**

Provide a National Association of Insurance Commissioners (NAIC) biographical affidavit (OIR-C1-1423) for each officer, director or shareholder listed in Section IV-1. All questions must be answered and yes answers must be accompanied by an explanation. Each Biographical Affidavit must contain the original signature of the respective officer, director or shareholder and an original notary seal. Submit the original of each biographical affidavit.

The requirement for the affiant's social security as part of the Biographical Affidavit is mandatory. However, pursuant to sections 119.071(5), Florida Statutes, social security numbers collected by an agency are confidential and exempt from section 119.07(1), Florida Statutes, and section 24(a), Art. I of the State Constitution and must be segregated on a separate page. Therefore, instead of including the SSN on page 1 of the Biographical Affidavit, 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), 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

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
MEDICARE PLUS CHOICE PROVIDER SPONSORED ORGANIZATIONS (PSO)**

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            Investigative Background Reports**

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 OIR-C1-905 for instructions.

**Section IV-5            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.

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
MEDICARE PLUS CHOICE PROVIDER SPONSORED ORGANIZATIONS (PSO)**

**SECTION V - HCFA MEDICARE FORMS AND RATES**

Submit to the Office of Insurance Regulation an affidavit attesting to the utilization of HCFA authorized forms and rates.

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
 MEDICARE PLUS CHOICE PROVIDER SPONSORED ORGANIZATIONS (PSO)**

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

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

<u>Item #</u>		<u>Completion Check List</u>
1.	Application Fees Paid .....	<input type="checkbox"/>
	(a) Copy of invoice included (Official Form).....	<input type="checkbox"/>
	(b) Copy of check included .....	<input type="checkbox"/>
	(c) Check mailed to address on Invoice .....	<input type="checkbox"/>
2.	Fingerprint fee paid electronically .....	<input type="checkbox"/>
	(a) Copy of on-line payment confirmation .....	<input type="checkbox"/>
	or, if applicable	
	(b) Copy of invoice included (Official Form) .....	<input type="checkbox"/>
	(b) Copy of check included .....	<input type="checkbox"/>
	(c) Check mailed to address on Invoice .....	<input type="checkbox"/>
3.	Deposits .....	<input type="checkbox"/>
	(a) Evidence of deposit with Collateral Management .....	<input type="checkbox"/>
4.	Application for Certificate of Authority (Official Form).....	<input type="checkbox"/>
	(a) Application form completed .....	<input type="checkbox"/>
	(b) Sealed by corporation.....	<input type="checkbox"/>
	(c) Signed by President and other authorized officer (original signature) .....	<input type="checkbox"/>
	(d) Notarized.....	<input type="checkbox"/>

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
 MEDICARE PLUS CHOICE PROVIDER SPONSORED ORGANIZATIONS (PSO)**

**SECTION II - LEGAL**

<u>Item #</u>	<u>Completion Check List</u>
1. Articles of Incorporation .....	<input type="checkbox"/>
(a) Original certification by Florida Secretary of State .....	<input type="checkbox"/>
(b) Articles with all amendments attached .....	<input type="checkbox"/>
2. Certificate of Status from Florida Secretary of State, signed by proper public official (original document).....	<input type="checkbox"/>
3. Corporate bylaws, rules and regulations, and/or Constitution.....	<input type="checkbox"/>
(a) Signed and dated by corporate secretary .....	<input type="checkbox"/>
(b) Corporate seal affixed.....	<input type="checkbox"/>
4. Health Care Provider Certificate .....	<input type="checkbox"/>
Documentation of a Health Care Provider Certificate or proof of a pending application with AHCA .....	<input type="checkbox"/>
5. Outside Representative Authorization Letter.....	<input type="checkbox"/>

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
MEDICARE PLUS CHOICE PROVIDER SPONSORED ORGANIZATIONS (PSO)**

**SECTION III - FINANCIAL AND RELATED INFORMATION**

<u>Item #</u>		<u>Completion Check List</u>
1.	Financial Statements .....	<input type="checkbox"/>
	(a) Current audited financial statements.....	<input type="checkbox"/>
2.	Financial Plan.....	<input type="checkbox"/>
	(a) Detailed marketing plan.....	<input type="checkbox"/>
	(b) A statement of revenue & expense on accrual basis.....	<input type="checkbox"/>
	(c) Cash flow statement .....	<input type="checkbox"/>
	(d) Balance sheets .....	<input type="checkbox"/>
	(e) Assumptions supporting financial plan .....	<input type="checkbox"/>
	(f) Availability of resources to meet projected losses .....	<input type="checkbox"/>
	(g) Statement of Initial Cash.....	<input type="checkbox"/>
	(h) History .....	<input type="checkbox"/>
	(i) Contingency Plans.....	<input type="checkbox"/>
	(j) Feasibility study .....	<input type="checkbox"/>

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
 MEDICARE PLUS CHOICE PROVIDER SPONSORED ORGANIZATIONS (PSO)**

<u>Item #</u>		<u>Completion Check List</u>
3.	Insurance .....	<input type="checkbox"/>
	(a) Copy of current general liability policy or plan for self-insurance ... <b>and</b> Current medical malpractice policy or plan for self-insurance .....	<input type="checkbox"/> <input type="checkbox"/>
	(b) Evidence of current fidelity bond .....	<input type="checkbox"/>
	(c) Reinsurance treaty.....	<input type="checkbox"/>
4.	Contracts .....	<input type="checkbox"/>
	(a) Provider contract form and signature pages .....	<input type="checkbox"/>
	(b) Other forms of contracts .....	<input type="checkbox"/>
5.	Grievance Procedure .....	<input type="checkbox"/>
	(a) Formal and informal steps included .....	<input type="checkbox"/>
6.	Bankruptcy Proceedings.....	<input type="checkbox"/>
	(a) Acknowledgement filed.....	<input type="checkbox"/>
	(b) Waiver for bankruptcy proceeding.....	<input type="checkbox"/>
	(c) Acknowledgement for bankruptcy proceeding.....	<input type="checkbox"/>

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
 MEDICARE PLUS CHOICE PROVIDER SPONSORED ORGANIZATIONS (PSO)**

**SECTION IV - MANAGEMENT**

<u>Item #</u>	<u>Completion Check List</u>
1.	Listing of all officers, directors, and stockholders, etc ..... <input type="checkbox"/>
(a)	Separate listing of all officers and directors for the corporation (Official Form)..... <input type="checkbox"/>
(b)	Separate listing of stockholders, including percentage held and number and class of shares (Official Form) ..... <input type="checkbox"/>
(c)	Chart of parent company ..... <input type="checkbox"/>
2.	Biographical Statement and Affidavits as requested in Section IV-1 A and B (Official Form)..... <input type="checkbox"/>
	For each biographical affidavit:
(a)	All blanks completed ..... <input type="checkbox"/>
(b)	"Yes" answers explained ..... <input type="checkbox"/>
(c)	Contains original signature ..... <input type="checkbox"/>
(d)	Notarized (original)..... <input type="checkbox"/>
(e)	Original of each affidavit submitted ..... <input type="checkbox"/>
4.	Investigative Background Report for each individual requested in Section IV-1 A and B ..... <input type="checkbox"/>
5.	Fingerprint cards enclosed for each person listed Section IV-1 A and B..... <input type="checkbox"/>
(a)	Contains original signature ..... <input type="checkbox"/>
(b)	Card furnished by Office of Insurance Regulation ..... <input type="checkbox"/>

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
MEDICARE PLUS CHOICE PROVIDER SPONSORED ORGANIZATIONS (PSO)**

(c) All information completed (DOB, Citizenship,  
Vital Statistics) .....

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
MEDICARE PLUS CHOICE PROVIDER SPONSORED ORGANIZATIONS (PSO)**

**SECTION V - FORMS AND RATES**

<u>Item #</u>	<u>Completion Check List</u>
1. Affidavit.....	<input type="checkbox"/>

**RETURN THE COMPLETED CHECKLIST WITH THE APPLICATION PACKAGE.**

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
MEDICARE PLUS CHOICE PROVIDER SPONSORED ORGANIZATIONS (PSO)**

Application is hereby submitted to form and operate a Medicare Plus Choice Provider Sponsored Organization.

Proposed name of Medicare Plus Choice Provider Sponsored Organization:

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

FEDERAL IDENTIFICATION NUMBER: \_\_\_\_\_

PHONE: \_\_\_\_\_

SOLVENCY CONTACT PERSON: \_\_\_\_\_

ATTORNEY OR PRINCIPAL FILING THIS APPLICATION:

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

PHONE: \_\_\_\_\_

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
MEDICARE PLUS CHOICE PROVIDER SPONSORED ORGANIZATIONS (PSO)**

This company, through its duly authorized officers, hereby applies for a certificate of authority authorizing and empowering it to operate as a Medicare Plus Choice Provider Sponsored Organization in the state of Florida, under the laws thereof, and do hereby swear or affirm that all of the responses, information, exhibits, and documentary evidence submitted in support of this application are true and correct.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

\_\_\_\_\_  
President or other authorized officer (please print)

(Corporate Seal)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Second authorized officer (please print)

\_\_\_\_\_  
Signature

State of \_\_\_\_\_

County of \_\_\_\_\_

Sworn to and subscribed before me

this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

\_\_\_\_\_  
Notary Public

(Notary Seal)

My Commission Expires

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
MEDICARE PLUS CHOICE PROVIDER SPONSORED ORGANIZATIONS (PSO)**

**INVOICE**

**NAME OF MEDICARE PLUS CHOICE PROVIDER SPONSORED ORGANIZATION:**

\_\_\_\_\_

**FEIN:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**CITY, STATE & ZIP CODE:** \_\_\_\_\_

**PHONE NUMBER:** \_\_\_\_\_

**ADDRESS (IF DIFFERENT FROM ARRANGEMENT ADDRESS)**

\_\_\_\_\_

\_\_\_\_\_

**(CITY)**

**(STATE)**

**(ZIP CODE)**

In reference to the submission of the above-referenced insurer's application to do business in Florida, it is necessary for this form to be returned with proper payment.

**PLEASE NOTE:**

1. Send a check in the proper amount made payable to the Florida Department of Financial Services and mail the check and invoice to the Florida Department of Financial Services, Bureau of Financial Services, Post Office Box 6100, Tallahassee, Florida 32314-6100.
  
2. Include a copy of the check and a copy of the invoice with the completed application package that is submitted to the Office of Insurance Regulation, Applications Coordination Section, 200 East Gaines Street, Tallahassee, Florida 32399-0332.

**For Accounting Use Only**

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<u>B/T</u>	<u>TY/CL</u>	<u>F/T</u>	<u>AMOUNT</u>
C	12/47	F	\$1,000