



DEPARTMENT OF FINANCIAL SERVICES
Office of Insurance Regulation

**APPLICATION FOR CERTIFICATE OF AUTHORITY
COMMERCIAL SELF-INSURANCE FUND**

The Certificate of Authority for a Commercial Self-Insurance Fund authorizes such insurer organized under the laws of the State of Florida, to transact the business of insurance other than life or title insurance.

This package is designed to assist the individuals in preparing the application with all the information required by statute and facilitate expeditious processing of that application by the Office of Insurance Regulation. This package includes four (4) categories of information:

Section I	Application Form & Fees
Section II	Legal
Section III	Financial
Section IV	Management

Each of these sections is processed by different bureaus of the Office, therefore it is necessary that the entire package be submitted in duplicate. It is extremely important that the application be completed in its entirety in the format specified.

Please submit your package tabularized in a binder that has been two-hole punched at the top, with tabs at the bottom. (Example: tab labeled IV-2 would contain Biographical Affidavits).

You are not required to have your policy rates approved as a condition precedent to receiving a license. These forms and rates may be submitted anytime after filing for the Certificate of Authority and must be approved prior to transacting any business. Submissions should be sent/linked to <https://portal.fdfs.com/ifile/default.asp>

You are cautioned not to write business using unapproved forms and rates.

Mail the completed application package to:

Florida Office of Insurance Regulation
Applications Coordinator
200 East Gaines Street, Larson Building
Tallahassee, Florida 32399-0332

THE COMPLETED CHECKLIST MUST BE RETURNED WITH THE APPLICATION PACKAGE!

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
COMMERCIAL SELF-INSURANCE FUND**

**INSTRUCTIONS
SECTION I - APPLICATION FORM & FEES**

Section I-1 Application Fees

Applicants must pay an application fee of \$1,500 and a company license tax of \$1,000. These fees are due at the time the application package is filed, and the filing fee is NON-REFUNDABLE.

Secure your check to the INVOICE (included in this package) and send to:

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

Place a copy of the INVOICE and a copy of the check with your application filing. This procedure will expedite the processing of your application and assure a timely recording of the fees.

Section I-2 Fingerprint Fees

Applicants are required to pay a fee for the processing of the fingerprint cards required in section IV-5. The fingerprint cards along with the fees are due at the time the application is filed. A set of Instructions for completing the fingerprint cards is included with this package.

Secure your check to the INVOICE (included in this package) and send to:

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

Place a copy of the INVOICE and a copy of the check in the management section (IV-5) of your application.

Section I-3 Company Application for Certificate of Authority (Official Form)

On this form, list the lines of business by code (see enclosed classifications and code number form) you intend to write in the State of Florida. The lines of business listed must be consistent with the lines listed in the plan of operations submitted with this package. When a Certificate of Authority is issued by the Office of Insurance Regulation, it will

include only those lines listed on this form and addressed in the pro formas in the plan of operations. It must be signed (original signatures) by both the President or Chief Executive Officer and the Secretary of the company.

**APPLICATION FOR CERTIFICATE OF AUTHORITY
COMMERCIAL SELF-INSURANCE FUND**

SECTION II - LEGAL

THE OFFICE OF INSURANCE REGULATION RECOMMENDS THAT CORPORATE DOCUMENTS BE REVIEWED BY YOUR LEGAL COUNSEL. THE OFFICE IS A FILING AGENCY AND AS SUCH DOES NOT RENDER ANY LEGAL, ACCOUNTING OR TAX ADVICE. THE PROFESSIONAL ADVICE OF YOUR LEGAL COUNSEL TO ASCERTAIN EXACT COMPLIANCE WITH ALL STATUTORY REQUIREMENTS IS STRONGLY RECOMMENDED. A PORTION OF THE FLORIDA STATUTES CHAPTER 624 DEALING WITH COMMERCIAL SELF-INSURANCE FUNDS IS INCLUDED IN THIS PACKAGE.

Section II-1 Consent and Agreement in re Service of Process (Official Form)

The Consent and Agreement in re Service of Process form (form attached) is to be accompanied by the Resolution of the Board of Trustees authorizing execution thereof (Section II-2). **NO** other signature will be accepted other than that of the Chairman of the Board of Trustees which must be under seal.

Section II-2 Resolution Form - (Consent and Agreement in re Service of Process Official Form)

This resolution (form attached) gives specific authority to the Chairman of the Board of Trustees to execute the agreement. The enclosed Office of Insurance Regulation Resolution Form must be used. Individualized or amended forms are unacceptable. **NO** other signatures will be accepted other than those of the Chairman of the Board of Trustees and Secretary which must be under seal.

Section II-3 Proposed Constitution, Bylaws and/or Trust Agreement

Submit unexecuted copies of the proposed constitution, bylaws and/or trust agreement. The constitution, bylaws, or trust agreement shall contain a provision prohibiting any distribution of surplus or profit except to members of the fund, as approved by the Department pursuant to s. 624.473.

Section II-4 Indemnity Agreement

Submit copies of properly executed indemnity agreements binding each fund member to individual, several, and proportionate liability as set forth in s. 624.472 and 624.474.

Section II-5 Sponsoring Organization

Submit the following documents from the sponsoring organization:

- (a) Certified Articles of Incorporation as received from the Secretary of State **(The Originals)**.
- (b) A Certificate of Status from the Secretary of State. (The Original).
- (c) A **Certified** copy of the bylaws or constitution signed, dated, and sealed by Secretary of the sponsoring organization.
- (d) A brief history of the sponsoring organization including: the type of association or entity (trade association, professional association, industry association, or self insurance trust fund), the address and phone number of the sponsoring organization, the date the sponsor was incorporated, and whether or not the sponsor has been in continuous operation since the date of organization.

**APPLICATION FOR CERTIFICATE OF AUTHORITY
COMMERCIAL SELF-INSURANCE FUND**

SECTION III - FINANCIAL

Section III-1 Statutory Deposit

Pursuant to Section 624.466 (9), a Commercial Self-Insurance Fund shall be required to file a statutory deposit with the Office for the protection of the insurer's policyholders and creditors. This deposit shall have at all times a value of not less than \$100,000. In lieu of a deposit, a fund may file with the Office a surety bond in a like amount (official surety bond form attached).

Contact the Bureau of Collateral Management, Insurance Deposits Section, (850) 413-3167 for the procedures involved in establishing a deposit.

Include a verification from the Bureau of Collateral Management that the funds have been deposited or the surety bond.

Section III-2 Verification of Funds

At least 10 days prior to the proposed effective date of the issuance of any policy, the trustees shall submit proof that the members have paid into a common claims fund in a designated depository cash premiums in an amount not less than \$50,000 or 10% of the estimated annual premium of the members at the inception, whichever is greater.

The funds must be verified by a letter from an officer of the financial institution where the funds are being held and should include the following:

1. Name of depositor and Federal ID Number.
2. Account numbers and amounts of funds in each account.
3. Form of funds on deposit.
4. Any restrictions on the withdrawal of the funds.

Section III-3 Plan of Operation

It is important for the Office to have a clear understanding of the proposed operations of the new insurer and the goals it seeks to achieve. To meet this requirement the applicant shall furnish a three-year Plan of Operations. If the applicant company is owned or controlled by a Financial Institution as defined in Section 626.9885, Florida Statutes, please refer to restrictions outlined in this statute when developing the Plan of Operations. A copy of this statute is included with this package. The plan must include all major areas of the

proposed operations including but not limited to the following:

- (A) A brief description of the management experience of each individual (by name) involved in the following areas: Marketing, Underwriting, Rating, Reserving, Reinsurance, Claims Handling, Accounting, Investments, and Managing General Agents.
- (B) Description of each line of insurance products to be marketed and planned dates of initial marketing of each line.
- (C) A three year plan of marketing, including commission rates, use of brokering agents, third party administrators, and other administrative expenses.
- (D) Provide planned use of reinsurance including the purpose of the reinsurance and the degree to which it is to be used in relation to the amount of insurance in force. Include copies of policies and agreements. These should detail retentions and limits of liability for the proposed reinsurance as well as catastrophe and coverage of the largest amount retained on one risk.
- (E) Submit a statement regarding any planned changes in operations during the next three years. If no changes are planned, a statement to that effect.
- (F) Provide a list of all assumptions used in projections and pro formas and disclose how these assumptions were derived. The assumptions should at least address how the premium levels have been derived, commission rates, investment income yields, expense levels, and benefits payable under accident and health policies and contracts.
- (G) Furnish pro forma statutory balance sheet and statutory income and expense statements covering the accounts in the Exhibit A format on the attached forms (5-22). If you should have any questions concerning individual line items please refer to the NAIC instructions to the annual statement.
- (H) Furnish a list of all consultant and expert services in use or proposed during the three year period.
- (I) Provide planned premium volume for countrywide premium and Florida premium by line of insurance at three month intervals for a three year period from initial marketing date for each line of insurance.

The Plan of Operation should also include a statement prepared by an actuary who is a member of the American Academy of Actuaries or the Casualty Actuarial Society establishing that the fund has prepared a plan of operation which is based on sound actuarial principles.

Section III-4 Membership Applications

Submit a membership application for each member applying for coverage with the Fund. Each of the charter members must submit a completed application.

Section III-5 Financial Statements

Submit a current financial statement for each of the charter members of the Fund. Each of the charter members must submit a financial statement.

Section III-6 Previous Florida Business History of Parent Company

In this section the parent company (if applicable) should detail any history that it has had in withdrawing from Florida as a whole or in discontinuing a particular line of business in this state.

Section III-7 Fidelity Bond

Pursuant to section 624.466(11) a bond (or insurance policy) in the amount of no less than 10% of the funds handled annually and issued in the name of the fund covering its trustees, employees, administrator, or other individuals managing or handling the funds or assets of the fund.

Section III-8 Contract Between Proposed Fund and Agent

Submit a complete copy of any contracts between the proposed fund and any agent(s).

Section III-9 Administrators Agreement

Submit a complete copy of any proposed contract(s) or agreements between the proposed fund and the administrator.

Section III-10 Policies and Endorsements

You are not required to have your policy rates approved as a condition precedent to receiving a license. These forms and rates may be submitted anytime after filing for the Certificate of Authority and **MUST** be approved prior to transacting any business. Submissions should be sent/linked to <https://iportal.fldfs.com/ifile/default.asp>

**APPLICATION FOR CERTIFICATE OF AUTHORITY
COMMERCIAL SELF-INSURANCE FUND**

SECTION IV - MANAGEMENT

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

Section IV-1 Trustees and Administrator Listing

Submit a list (official form) listing the names of all trustees and officers or directors of the administrator and their relationship (owner, partner, officer, director, or employee) to the fund. If the administrator is a partnership, then information should be submitted for all partners.

Section IV-2 Biographical Affidavits as to each Trustee of the proposed Fund and officer or director of the proposed Administrator (Official Form Enclosed).

A biographical affidavit (**Official Florida Form Only!**) must be completed for each person 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 trustee, officer, or director with an original notary seal. **Please file an original of each Biographical Affidavit for each person in the order of listing in Section IV-1.**

The requirements for the affiant's social security as part of the Biographical Affidavit is mandatory. However, pursuant to sections 119.0721(1) and (8), 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 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 119.0721(8), 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.

Section IV-3 Authority for Release of Information (Official Form Enclosed)

An Authority for Release of Information form must be completed for each person listed in Section IV-1 using the attached form. Each Authority for Release form must contain an original signature of the respective trustee, officer or director and an original notary seal. **Please file an original of each Authority for Release of Information Form for each person in the order of listing in Section IV-1.**

Section IV-4 Investigative Background Report

An Investigative Background Report must be provided for each person listed in Section IV-1 above. 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 fingerprint cards along with the fees are due at the time the application is filed. **No fingerprint cards, other than those furnished by the Office, will be accepted.** These cards must be completed at a law enforcement or similar type agency and returned to this Office for processing. A set of instructions for completing the fingerprint cards is included with this package.

PLEASE NOTE: Information which has been entered on the cards may not be altered in any way, i.e., erased, covered with correction fluid, marked out, etc. In addition, cards may not be folded, stapled, torn or marred in any way.

**APPLICATION FOR CERTIFICATE OF AUTHORITY
COMMERCIAL SELF-INSURANCE FUND**

CHECK LIST

SECTION I - APPLICATION FORM AND RELATED FEES

Company Name: _____

<u>Item #</u>	<u>Completion Check List</u>
1. Insurer application fees paid	<input type="checkbox"/>
(a) Copy of invoice included.....	<input type="checkbox"/>
(b) Copy of check	<input type="checkbox"/>
2. Fingerprint fees paid (If Applicable)	<input type="checkbox"/>
(a) Copy of invoice included.....	<input type="checkbox"/>
(b) Copy of check	<input type="checkbox"/>
3. Company Completed Application for License (Official Form)	<input type="checkbox"/>
(a) All classes of insurance to be transacted listed by code number	<input type="checkbox"/>
(b) Sealed by Company	<input type="checkbox"/>
(c) Signed by (original signatures)	
1. Chairman of Board of Trustees	<input type="checkbox"/>
2. Secretary	<input type="checkbox"/>

**APPLICATION FOR CERTIFICATE OF AUTHORITY
COMMERCIAL SELF-INSURANCE FUND**

SECTION II - LEGAL DOCUMENTS

Company Name: _____

<u>Item #</u>		<u>Completion Check List</u>
1.	Consent and Agreement in re Service of Process	<input type="checkbox"/>
	(a) Signed by Chairman of Board of Trustees	<input type="checkbox"/>
	(b) Signed by Secretary	<input type="checkbox"/>
	(c) Sealed with company seal.....	<input type="checkbox"/>
	(d) Original.....	<input type="checkbox"/>
2.	Resolution Form.....	<input type="checkbox"/>
	(a) Signed by Chairman of Board of Trustees	<input type="checkbox"/>
	(b) Signed by Secretary	<input type="checkbox"/>
	(c) Sealed with company seal.....	<input type="checkbox"/>
	(d) Original.....	<input type="checkbox"/>
3.	Proposed Constitution/Bylaws	<input type="checkbox"/>
	(a) Unexecuted.....	<input type="checkbox"/>
	(b) Original.....	<input type="checkbox"/>
	(c) Three copies	<input type="checkbox"/>

**COMMERCIAL SELF-INSURANCE FUND
SECTION II – LEGAL DOCUMENTS, PAGE TWO**

- 4. Indemnity Agreement.....
- (a) Executed
- (b) Originals.....
- 5. Sponsoring Organization Documents
- (a) Articles of Incorporation (certified originals)
- (b) Certificate of Status (original)
- (c) Copy of Bylaws or Constitution.....
- (d) Miscellaneous statements

**APPLICATION FOR CERTIFICATE OF AUTHORITY
COMMERCIAL SELF-INSURANCE FUND**

SECTION III- FINANCIAL

Company Name: _____

<u>Item #</u>	<u>Completion Check List</u>
1. Verification of Statutory Deposit.....	<input type="checkbox"/>
(a) Letter from Collateral Management showing amount of deposit	<input type="checkbox"/>
2. Verification of Funds on Deposit.....	<input type="checkbox"/>
(a) Letter from financial institution showing:	
(1) Amount of Deposit.....	<input type="checkbox"/>
(2) Name of Depositor	<input type="checkbox"/>
(3) Federal ID number	<input type="checkbox"/>
(4) Form of funds	<input type="checkbox"/>
(5) Account numbers	<input type="checkbox"/>
(6) Amount in each account.....	<input type="checkbox"/>
(7) Any restrictions on withdrawals.....	<input type="checkbox"/>
3. Plan of Operations (two copies).....	<input type="checkbox"/>
4. Membership Application for each member.....	<input type="checkbox"/>
5. Current Financial Statement for each member	<input type="checkbox"/>
6. Previous Florida Business History Statement	<input type="checkbox"/>

**COPMMERCIAL SELF INSURANCE FUND
SECTION III – FINANCIAL, PAGE TWO**

- 7. Copy of Fidelity Bond required in section 624.466(11)
- 8. Copy of contract between Fund and Agent(s)
- 9. Administrators Agreement
- 10. Policies and Endorsements submitted as directed.....

**APPLICATION FOR CERTIFICATE OF AUTHORITY
COMMERCIAL SELF-INSURANCE FUND**

SECTION IV- MANAGEMENT

Company Name: _____

<u>Item #</u>	<u>Completion Check List</u>	
1.	Listing of all Trustees of Fund and Officers and Directors of Administrator (Official Form)	<input type="checkbox"/>
(a)	Full names listed	<input type="checkbox"/>
(b)	Titles listed	<input type="checkbox"/>
2.	Biographical affidavits as to Trustees of Fund and Officers and Directors of Administrator (Official Form)	<input type="checkbox"/>
	As to each biographical:	
(a)	All blanks filled in	<input type="checkbox"/>
(b)	Yes answers explained.....	<input type="checkbox"/>
(c)	Contains original signature of each respective officer, director or trustee	<input type="checkbox"/>
(d)	Notarized (Original).....	<input type="checkbox"/>
(e)	Submitted original of each affidavit.....	<input type="checkbox"/>
3.	Authority for Release of Information as each Trustee of the Fund and officer and director of the Administrator (Official Form)	<input type="checkbox"/>
(a)	Contains original signature of each respective officer, director or trustee.....	<input type="checkbox"/>

**COMMERCIAL SELF INSURANCE FUND
SECTION IV – MANAGEMENT, PAGE TWO**

- (b) Notarized (original).....
- (c) Submitted original of each release form.....
- 4. Background investigation reports for persons listed in Section IV-1
- 5. Fingerprint cards enclosed for each person listed in section IV-1 (If applicable).....
 - (a) Contains original signature of each respective officer, director or trustee.....
 - (b) Office of Insurance Regulation card only
 - (c) No erasures or alterations on cards
 - (d) All blanks filled in

INVOICE

DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
COMMERCIAL SELF-INSURANCE FUND

APPLICATION FOR CERTIFICATE OF AUTHORITY
COMMERCIAL SELF-INSURANCE FUND

NAME OF COMPANY: _____

FEIN _____

ADDRESS: _____

CITY, STATE & ZIP CODE: _____

PHONE NUMBER: _____

ADDRESS (IF DIFFERENT FROM COMPANY ADDRESS)

(CITY) (STATE) (ZIP CODE)

1. Make payable to the Florida Department of Financial Services and mail check and invoice only to the Department of Financial Services, Bureau of Financial Services, P.O. Box 6100, Tallahassee, Florida 32314-6100.

2. Send a copy of the check and a copy of the invoice along with the completed application package to the Department of Financial Services, Office of Insurance Regulation, Applications Section, Larson Building, Tallahassee, Florida 32399-0332.

TYPE: 10 CLASS: 30 Company License Tax \$1,000.00

TYPE: 10 CLASS: 06 Filing Fee \$1,500.00

Total \$2,500.00

**INVOICE
DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
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 a copy of the **invoice** along with the completed application package to the Florida Department of Financial Services, Office of Insurance Regulation, Applications Section, 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 ... \$ _____

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

APPLICATION FOR LICENSE TO CONDUCT BUSINESS IN THE STATE OF FLORIDA
(Commercial Self-Insurance Fund)

_____, 20____

TO THE DIRECTOR, OFFICE OF INSURANCE REGULATION,
TALLAHASSEE, FLORIDA

SIR: The _____
(Give name of proposed Fund)

Federal Identification Number _____

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

Phone Number _____

through its duly authorized officers, hereby applies for license authorizing and empowering the Company or Association aforesaid to transact the following kinds of insurance or branches of business in the State of Florida, under the laws thereof, during the year ending May 31, 20____.

Class of Business

Code Number

By _____
Chairman Board of Trustees

Attest _____
Secretary

**FLORIDA DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
PROPERTY AND CASUALTY INSURERS
LINES OF BUSINESS BY COMPANY CODE**

0010 Fire
0020 Allied Lines
0030 Farmowners Multi Peril
0040 Homeowners Multi Peril
0050 Commercial Multi Peril
0080 Ocean Marine
0090 Inland Marine
0100 Financial Guaranty
*0106 Auto Warranties
0110 Medical Malpractice
0120 Earthquake
0160 Workers' Compensation
0170 Other Liability
*0173 Prepaid Legal
0192 Private Passenger Auto Liability
0194 Commercial Auto Liability
0211 Private Passenger Auto Physical Damage
0212 Commercial Auto Physical Damage
0220 Aircraft
0230 Fidelity
0240 Surety
*0245 Bail Bonds
0250 Glass
0260 Burglary and Theft
0270 Boiler and Machinery
0280 Credit
*0285 Title (Title Companies Only)
*0290 Livestock
0300 Industrial Fire
*0310 Mortgage Guaranty
0441 Credit Disability
*0450 Accident and Health
*0520 Industrial Extended Coverage
*0540 Mobile Home Multi Peril
*0550 Mobile Home Physical Damage
*0570 Crop Hail
*0607 Home Warranties
*0608 Service Warranties
*0610 Other Warranty
*0620 Miscellaneous Casualty

*For purposes of applicant's plan of operations, these lines should be listed as "all other lines". If any are combined with other lines on the pro forma's (i.e. mobile home combined with homeowners), the plan of operations should specify that this was done.

LINES OF BUSINESS BY COMPANY CODE (REINSURANCE)

R010 Reinsurance - Fire
R020 Reinsurance - Allied Lines
R030 Reinsurance - Farmowners Multi Peril
R040 Reinsurance - Homeowners Multi Peril
R050 Reinsurance - Commercial Multi Peril
R080 Reinsurance - Ocean Marine
R090 Reinsurance - Inland Marine
R100 Reinsurance - Financial Guaranty
*R106 Reinsurance - Auto Warranties
R110 Reinsurance - Medical Malpractice
R120 Reinsurance - Earthquake
R160 Reinsurance - Workers' Compensation
R170 Reinsurance - Other Liability
*R173 Reinsurance - Prepaid Legal
R192 Reinsurance - Private Passenger Auto Liability
R194 Reinsurance - Commercial Auto Liability
R211 Reinsurance - Private Passenger Auto Physical Damage
R212 Reinsurance - Commercial Auto Physical Damage
R220 Reinsurance - Aircraft
R230 Reinsurance - Fidelity
R240 Reinsurance - Surety
*R245 Reinsurance - Bail Bonds
R250 Reinsurance - Glass
R260 Reinsurance - Burglary and Theft
R270 Reinsurance - Boiler and Machinery
R280 Reinsurance - Credit
*R290 Reinsurance - Livestock
R300 Reinsurance - Industrial Fire
*R310 Reinsurance - Mortgage Guaranty
R441 Reinsurance - Credit Disability
*R450 Reinsurance - Accident and Health
*R520 Reinsurance - Industrial Extended Coverage
*R540 Reinsurance - Mobile Home Multi Peril
*R550 Reinsurance - Mobile Home Physical Damage
*R570 Reinsurance - Crop Hail
*R607 Reinsurance - Home Warranties
*R608 Reinsurance - Service Warranties
*R610 Reinsurance - Other Warranty
*R620 Reinsurance - Miscellaneous Casualty

**CONSENT AND AGREEMENT IN RE SERVICE OF PROCESS
FOR COMMERCIAL SELF-INSURANCE FUND**

State of: _____

County of: _____

Know all men by these presents, that the _____

a Commercial Self-Insurance Fund duly organized and existing under and by virtue of the Laws of the State of Florida, does hereby agree and consent that actions may be commenced against it in the proper Court of any County in the State of Florida, in which a cause of action may arise, or in which the plaintiff may reside, by the service of process upon the Chief Financial Officer of the State of Florida as ex officio Insurance Commissioner, hereby stipulating and agreeing that such service shall be taken and held in all Courts to be as valid and binding upon this fund as if personal service has been made upon the trustees or any other duly authorized and accredited officer thereof. Hereby further agreeing and stipulating that this consent and agreement is and shall remain irrevocable, so long as there is liability, under any policy or claim, within this State, either fixed or contingent. Said Fund does hereby designate _____

as the name and address of the person to whom process against it served upon said Chief Financial Officer is to be forwarded. In the event of a change in the designation of the person to whom process is to be forwarded, the fund shall file same with the Chief Financial Officer.

In witness thereof, I, Chairman of the Board of Trustees of said fund has hereunto set my hand on this the

_____ day of _____ A.D. 20 _____

SEAL

By: _____
Chairman of the Board of Trustees

The foregoing agreement must be accompanied by a duly certified copy of the order or resolution of the trustees of the fund authorizing the Chairman to execute the same for and on behalf of the fund.

**RESOLUTION FORM
FOR COMMERCIAL SELF-INSURANCE FUND**

I hereby certify that the following resolution was adopted by the entire Board of Trustees of

At a meeting held by the Trustees of the Commercial Self-Insurance Fund on the _____ day of _____, 20 ____:

"Resolved, that the Chairman of the Board of Trustees of this Fund is hereby authorized to execute, for and on behalf of this fund, the attached Consent and Agreement in Re Service of Process under the laws of Florida."

Trustee

Trustee

Trustee

Trustee

Trustee

Trustee

**State of Florida
Department of Financial Services
Office of Insurance Regulation**

Bond Number _____

KNOW ALL MEN BY THESE PRESENTS, THAT _____ AS
PRINCIPAL, (Hereinafter referred to as "the Principal") and _____ AS SURETY,
(Hereinafter referred to as "the Surety"), are held and firmly bound unto TOM GALLAGHER, Chief Financial
Officer of the State of Florida, and his successors in office, in the sum of ONE HUNDRED THOUSAND
DOLLARS (\$100,000) in lawful money of the United States, to the payment whereof we hereby bid
ourselves, jointly and severally, and our successors assigns and representatives.

Signed and sealed this _____ day of _____ A.D. 20 _____.

THE CONDITION OF THE ABOVE OBLIGATION IS, THAT, WHEREAS, by virtue of Section 624.466(9),
Florida Statutes, the above bounded, the Principal herein named, is required to deposit acceptable
securities with a value of ONE HUNDRED THOUSAND DOLLARS (\$100,000) of a surety company
authorized to do business in the State of Florida, said bond and company to be approved by said Chief
Financial Officer of the State of Florida to be held by the said Chief Financial Officer of the State of Florida
the faithful performance of its obligations to all parties to insurance contracts issued by the Commercial Self-
Insurance Fund and its obligations under Chapter 624, Florida Statutes, by said principal herein named, in
the State of Florida.

AND WHEREAS, the above bounden, the Principal herein named, has elected to give such surety bond with
the Surety above named:

NOW THEREFORE, if the said Principal named herein shall faithfully perform its obligations to all parties to
insurance contracts issued by the Commercial Self-Insurance Fund and its obligations under Chapter 624,
Florida Statutes, or otherwise imposed upon it by the Laws of the State of Florida, then and in that event this
bond shall be null and void.

IT IS FURTHER expressly understood and agreed by and between the parties hereto, that this bond may
not be cancelled or released until after 30 days notice in writing to the Chief Financial Officer of the State of
Florida provided such cancellation shall not release said Surety from any liability existing hereunder at the
time of the effective date of said cancellation.

THE SURETY does hereby grant a period of twelve (12) months from the effective date of said cancellation
or release in which to discover any obligation it may have had under this bond.

IN WITNESS WHEREOF, the said parties hereunto have caused to be set the hands of their respective
proper officers and to be affixed there respective corporate seal this _____ day of _____,
A.D. 20 _____.

Signed and sealed in the presence of:

By: _____

Executed at _____
Florida, this _____ day of _____, 20_____

By _____
Florida Resident Agent of Surety Company

NOTE: Attach to this bond a properly certified copy of the Agent's Power of Attorney

**FLORIDA DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
MANAGEMENT INFORMATION FORM
COMPLETE LISTING OF OFFICERS
DIRECTORS, AND SHAREHOLDERS (10% OR MORE)**

OFFICERS:

TITLES:

OWNERSHIP PERCENTAGE:

DIRECTORS:

SHAREHOLDERS:



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).

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

- Affiant's Social Security Number _____
- 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