



## APPLICATION FOR CERTIFICATE OF AUTHORITY DOMESTIC INSURER

This package is designed to assist individuals in preparing the Application for Certificate of Authority. It may be used for a life and health insurer or property and casualty insurer. It authorizes such insurer (stock, mutual, assessable mutual, captive) organized under the laws of the state of Florida, to transact the business of insurance. The Application for Certificate of Authority should be submitted only after the permit to organize a domestic insurer has been granted and the formation of the company has been completed. This application includes four (4) categories of information:

Section I	Application Form and Related Fees
Section II	Legal
Section III	Financial
Section IV	Management

Please submit the application in a tabbed binder. (Example: Tab III-1 would contain the Plan of Operations.)

The applicant is not required to have policy forms and rates approved as a condition precedent to receiving a certificate of authority, however, the company must have its forms and rates approved prior to writing business. The forms and rates may be submitted for approval anytime after filing the Application for Certificate of Authority.

Property and casualty insurers and Life, accident and health insurers should submit policy forms and rates to: <https://iportal.fldfs.com/ifile/default.asp>

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  
DOMESTIC INSURER**

**INSTRUCTIONS**

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

**Section I-1 Application Fees**

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

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

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

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

**Section I-2 Fingerprint Processing Fees**

Applicants are required to prepay electronically for the processing of the fingerprint cards required in section IV-4. 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-4).

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**

Submit the original Application for Certificate of Authority (official form enclosed) listing the lines of business (and respective code numbers) the company intends to write in the state of Florida, signed (original signatures) by the president or chief executive officer and the secretary of the company under corporate seal. The lines of business listed on this form must be consistent with the lines listed on the Application for Permit form or the applicant must file a new plan of operations with this application. When a Certificate of Authority is issued by the Office of Insurance Regulation, it will include only those lines listed on this form.

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
DOMESTIC INSURER**

**SECTION II - LEGAL**

**Section II-1 Authorization Letter**

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

**Section II-2 Service of Process Consent & Agreement**

Provide an executed Service of Process Consent & Agreement form (official form enclosed) under corporate seal and signed by the president or chief executive officer and secretary.

**Section II-3 Secretary of State Registration Requirements**

All domestic insurers must register as a domestic corporation with the Florida Secretary of State. The following items must be submitted to the Secretary of State in order to complete this filing:

- (a) The original executed articles of incorporation which were stamped approved by the Office of Insurance Regulation during the permit application; and
- (b) The Certificate of Designation Registered Agent/Registered Office (official form enclosed) designating the State Treasurer and Insurance Commissioner as the registered agent pursuant to Section 624.422, Florida Statutes.

For questions regarding the Secretary of State requirements and/or fees, please call the Division of Corporations at (850) 487-6052.

Send the above items to:

Secretary of State  
Division of Corporations  
PO Box 6327  
Tallahassee, Florida 32314  
(850) 245-6052

For courier service only send to:

Secretary of State  
Division of Corporations  
409 East Gaines Street  
Tallahassee, Florida 32399

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

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

**Section II-5 Certified Articles of Incorporation**

Provide the original certified articles of incorporation of the company from the Secretary of State.

**Section II-6 Company Bylaws**

Provide the original executed bylaws of the company signed and dated by the secretary of the company under corporate seal.

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
DOMESTIC INSURER**

**SECTION III - FINANCIAL**

**Section III-1 Plan of Operations**

If there have been any major changes since the application for permit, a new plan of operations must be submitted. The addition or deletion of lines of business constitutes a major change. If no changes have occurred since the permit was granted, submit a statement of such fact signed by at least two executive officers and under the company's corporate seal.

**Section III-2 Holding Company Registration Statement**

Provide a holding company registration statement if the insurer is a member of an insurance holding company system. A sample form is enclosed for use in fulfilling the requirement of a Florida domestic insurer. If the insurer is not a member of an insurance holding company system, a statement of such fact signed by at least two executive officers and under the insurer's corporate seal must be provided. Provide a copy of the SEC 10K statement, if applicable.

**Section III-3 Financial Statement Contact**

Provide the name and telephone number of the contact person responsible for the preparation of the financial statements of the applicant.

**Section III-4 Verification of Funds**

To obtain a Certificate of Authority in Florida, an insurer is required to have a minimum surplus as to policyholders as follows:

Property and casualty insurers:	greater of \$5 million or 10% of total liabilities
Title insurers:	greater of \$2.5 million or 10% of insurer's total liabilities
Assessable mutual insurers:	\$300,000 with respect to health insurance
	\$200,000 with respect to property insurance
	\$300,000 with respect to casualty insurance
	\$400,000 with respect to any combination of health, property, or casualty insurance
	\$2.5 million with respect to life insurance
Life insurers:	greater of \$2.5 million or 4% of insurer's total liabilities
Life and health insurers:	greater of \$2.5 million of 4% of the insurer's total liabilities plus six percent of the insurer's liabilities relative to health insurance
Captive insurers:	\$500,000 unimpaired paid-in capital and \$250,000 unimpaired surplus

## **APPLICATION FOR CERTIFICATE OF AUTHORITY DOMESTIC INSURER**

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

1. Name of depositor and federal identification number;
2. Account numbers and amount of funds in each account;
3. Form of funds on deposit;
4. If funds are a certificate of deposit, include certificate numbers and maturity dates; and
5. Verification that the funds are not encumbered, hypothecated, or pledged.

### **Section III-5 Statutory Deposit**

Every domestic insurer shall be required to place a statutory deposit with the Office of Insurance Regulation for the protection of the insurer's policyholders and creditors. This deposit must have at all times a value of not less than:

- (a) \$250,000 to transact casualty insurance;
- (b) \$100,000 to transact all other kinds of insurance, per kind of insurance; or
- (c) A maximum of \$300,000 for any insurer authorized to write more than one kind of insurance.

Contact the Bureau of Collateral Management, Public Deposits Section, (850) 413-3164 for the procedures to establish a deposit.

### **Section III-6 Participation Required in Statutorily Created Associations**

Submit a separate original executed Subscription Agreement Form (official form enclosed) under the insurer's corporate seal for each state guaranty and joint underwriting association in which the applicant must participate.

### **Section III-7 National Association of Insurance Commissioners (NAIC) Company Code Application**

Applicant must provide a copy of the notification statement mailed to the NAIC.

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
DOMESTIC INSURER**

**SECTION IV - MANAGEMENT**

**ANY INDIVIDUALS, NOT INCLUDED IN THE APPLICATION FOR PERMIT FILING, MUST PROVIDE ALL OF THE INFORMATION REQUESTED. NAMES REQUESTED IN THIS SECTION SHOULD INCLUDE FIRST, MIDDLE AND LAST NAMES (NO ABBREVIATIONS).**

**Section IV-1 Management Information**

Provide full names of all company incorporators, officers and directors, of the applicant, and all shareholders (owning 10% or more of the outstanding stock of the company) with their respective titles and ownership percentages.

As to the immediate parent and the ultimate parent of the applicant, if applicable, provide the full names and titles for the officers and directors who exercise control over the licensee and all shareholders owning or controlling 10% or more of the parent company's stock. If these entities are currently licensed in Florida by the Office of Insurance Regulation, only the Office's official Biographical Statement and Affidavit form will be required. Officers and directors of the immediate parent and ultimate parent who do not exercise control of the activities of the applicant are required to file the applicable Disclaimer of Control Affidavit in lieu of providing all of the required background information.

Companies in the organizational structure from, and including, the immediate parent through the ultimate parent, must provide the names and titles of all officers and directors.

Please use the attached Management Information Form.

**Section IV-2 Biographical Statement and Affidavits as to All Company Incorporators, Officers, Directors, and Shareholders**

Provide a National Association of Insurance Commissioners (NAIC) biographical affidavit (OIR-C1-1423) for each officer, director, and shareholder listed in Section IV-1 except for those filing a disclaimer and for those companies in the organizational structure between the immediate parent and the ultimate parent. All questions must be answered. All "Yes" answers must be explained.

Each biographical affidavit must be submitted to the Office containing an original signature and original notary seal. If, however, the biographical affidavits are currently on file and are not more than two years old, no submission is necessary.

The requirement for the affiant's social security number as part of the Biographical Affidavit is mandatory. However, pursuant to sections 119.071(5), 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 6 of the NAIC form, please include the affiant's name and social security number on a separate page and attach it to the Biographical Affidavit. Also please stamp CONFIDENTIAL at the top and bottom of the separate page.

Section 119.071(5), 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. The duties of the Office in background investigation are extensive in order to insure that the owners, management, officers, and directors of any insurer are competent and trustworthy, possess financial standing and business experience, and have not

been found guilty of, or not pleaded guilty or nolo contendere to, any felony or crime punishable by imprisonment of one year.

### **Section IV-3 Background Investigative Report**

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

### **Section IV-4 Fingerprint Cards**

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

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

Please place the completed fingerprint cards in this section.

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

If the fingerprint cards on file with the Office of Insurance Regulation are not more than five years old, new fingerprint cards will not be required.

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
DOMESTIC INSURER**

**CHECK LIST**

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

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

<u>Item #</u>		<u>Complete Check List</u>
1.	Application fees paid.....	<input type="checkbox"/>
	(a) Copy of invoice included .....	<input type="checkbox"/>
	(b) Copy of check.....	<input type="checkbox"/>
2.	Fingerprint processing fees paid electronically .....	<input type="checkbox"/>
	(a) No additional incorporators, officers, directors, and shareholders appointed since approved in Application for Permit filing.....	<input type="checkbox"/>
	or, if applicable	
	(b) Copy of on-line payment confirmation .....	<input type="checkbox"/>
	or, if applicable	
	(c) Copy of form OIR-C1-903 (invoice) included.....	<input type="checkbox"/>
	(d) Copy of check included .....	<input type="checkbox"/>
	(e) Originals mailed to Bureau of Financial Services .....	<input type="checkbox"/>
3.	Completed Application for Certificate of Authority (official form).....	<input type="checkbox"/>
	(a) All classes of insurance to be transacted listed by code number.....	<input type="checkbox"/>
	(b) Under corporate seal of company .....	<input type="checkbox"/>
	(c) Signed by (original signatures)	
	(1) President or Chief Executive Officer.....	<input type="checkbox"/>
	(2) Secretary .....	<input type="checkbox"/>

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
DOMESTIC INSURER**

**SECTION II - LEGAL**

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

<u>Item #</u>	<u>Complete Check List</u>
1. Authorization letter from company .....	<input type="checkbox"/>
2. Service of Process Consent and Agreement (official form) .....	<input type="checkbox"/>
(a) Signed and dated by	
(1) President or Chief Executive Officer.....	<input type="checkbox"/>
(2) Secretary .....	<input type="checkbox"/>
(b) Under corporate seal of company .....	<input type="checkbox"/>
3. Secretary of State registration completed .....	<input type="checkbox"/>
4. Original certificate of status issued by the Florida Secretary of State evidencing registration as a domestic insurer .....	<input type="checkbox"/>
5. Articles of incorporation .....	<input type="checkbox"/>
(a) Original certification by Florida Secretary of State .....	<input type="checkbox"/>
(b) Identify any changes if different since approved in Application for Permit filing.....	<input type="checkbox"/>
6. Company bylaws.....	<input type="checkbox"/>
(a) Signed and dated by Secretary .....	<input type="checkbox"/>
(b) Under corporate seal of company .....	<input type="checkbox"/>
(c) Identify any changes if different since approved in Application for Permit filing.....	<input type="checkbox"/>

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
DOMESTIC INSURER**

**SECTION III - FINANCIAL**

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

<u>Item #</u>	<u>Complete Check List</u>
1. Plan of operations .....	<input type="checkbox"/>
(a) Statement that company has made no changes .....	<input type="checkbox"/>
(1) Signed by two executive officers .....	<input type="checkbox"/>
(2) Under corporate seal of company .....	<input type="checkbox"/>
<b>or</b>	
(b) Revised plan of operations.....	<input type="checkbox"/>
(1) Revised plan of operations includes a revised checklist from Section III of the Permit application .....	<input type="checkbox"/>
(2) Identify all changes since approved in Application for Permit filing ....	<input type="checkbox"/>
2. Holding company registration statement.....	<input type="checkbox"/>
(a) Identify all changes since approved in Application for Permit filing.....	<input type="checkbox"/>
(b) Registration statement provided.....	<input type="checkbox"/>
(c) Statement that company is not a member of a holding company system .....	<input type="checkbox"/>
(1) Signed by two executive officers .....	<input type="checkbox"/>
(2) Under corporate seal of company .....	<input type="checkbox"/>
(d) SEC 10K statement (if applicable) .....	<input type="checkbox"/>
3. Name and telephone number of financial statement contact person provided .....	<input type="checkbox"/>
4. Annual statement (most current year) of immediate parent company, if any.....	<input type="checkbox"/>
(a) Signed by two executive officers .....	<input type="checkbox"/>
<b>and</b>	
(b) Notary seal .....	<input type="checkbox"/>

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
DOMESTIC INSURER**

Complete  
Check List

Item #

**or**

- (c) Certified by the state of domicile .....
- (d) Supplemental schedules included.....
- (e) Actuarial opinion included .....
- 5. Statutory financial statements audited by certified public accountant for immediate parent company, including letter of internal control.....
- 6. Organizational chart included if any changes since approved in Application for Permit filing.....
- 7. Statement of the method of financing ..... 
  - (a) Check box if no changes .....
  - (b) Identify any changes since approved in Application for Permit filing..... 
    - (1) Minimum surplus requirements met .....
    - (2) Copy of financing agreement, surplus note or other similar agreements involved in the financing of the insurer .....
    - (3) Source(s) and form of funds disclosed .....
    - (4) Amount(s) funded by each source.....
- 8. Verification of funds ..... 
  - (a) Letter issued by officer of financial institution.....
  - (b) Letter includes:
    - (1) Name of depositor and federal ID number .....
    - (2) Account numbers and amounts in accounts.....
    - (3) Form of funds .....

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
DOMESTIC INSURER**

<u>Item #</u>		<u>Complete Check List</u>
	(4) Certificate numbers and maturity dates of CD's .....	<input type="checkbox"/>
	(5) Verification that the funds are not encumbered, hypothecated, or pledged.....	<input type="checkbox"/>
9.	Verification of statutory deposit.....	<input type="checkbox"/>
	(a) Letter from Collateral Management showing amount of deposit .....	<input type="checkbox"/>
10.	Participation in statutorily required associations .....	<input type="checkbox"/>
	(a) Subscription Agreements (official form) .....	<input type="checkbox"/>
	(b) Under seal of company .....	<input type="checkbox"/>
11.	Copy of notification statement sent to NAIC .....	<input type="checkbox"/>
12.	Internal control procedures .....	<input type="checkbox"/>
	(a) Description of internal control procedures of company included.....	<input type="checkbox"/>

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
DOMESTIC INSURER**

**SECTION IV - MANAGEMENT**

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

<u>Item #</u>	<u>Complete Check List</u>
1. Identify any changes in applicant, immediate parent(s) and ultimate parent(s) incorporators, officers, directors, and shareholders (including entities) owning 10% or more since approved in Application for Permit filing.....	<input type="checkbox"/>
2. Listing of all company incorporators, officers, directors and shareholders (including entities) owning 10% or more of applicant.....	<input type="checkbox"/>
3. Listing of all immediate parent(s) officers, directors and shareholders (including entities) owning 10% or more of parent company's stock.....	<input type="checkbox"/>
4. Listing of all intermediary parent(s) (between immediate parent(s) and ultimate parent(s), officers, directors and shareholders (including entities) owning 10% or more of parent company's stock. Note, do not complete or order biographical statement and affidavits, background investigative reports or fingerprint cards .....	<input type="checkbox"/>
5. Listing of all ultimate parent(s) officers, directors and shareholders (including entities) owning 10% or more of parent company's stock .....	<input type="checkbox"/>
6. Biographical Statement and Affidavits for company incorporators, officers directors and shareholders (including entities) owning 10% or more of applicant .....	<input type="checkbox"/>
(a) No additional incorporators, officers, directors, and shareholders since approved in Application for Permit filing .....	<input type="checkbox"/>
<b>or as to each biographical:</b>	
(b) All information completed .....	<input type="checkbox"/>
(c) Contains original signature .....	<input type="checkbox"/>
(d) Notarized (original) .....	<input type="checkbox"/>
(e) Original filed .....	<input type="checkbox"/>

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
DOMESTIC INSURER**

Complete  
Check List

Item #

- |     |  |                          |
|-----|--|--------------------------|
| 7.  | Biographical Statement and Affidavits for immediate parent(s) officers, directors and shareholders (including entities) owning 10% or more of parent company's stock (Form OIR-C1-422, rev 10/98)..... | <input type="checkbox"/> |
|     | (a) No additional incorporators, officers, directors, and shareholders since approved in Application for Permit filing .....   | <input type="checkbox"/> |
|     | <b>or as to each biographical:</b>   |                          |
|     | (b) All information completed .....  | <input type="checkbox"/> |
|     | (c) Contains original signature .....  | <input type="checkbox"/> |
|     | (d) Notarized (original) .....   | <input type="checkbox"/> |
|     | (e) Original filed .....   | <input type="checkbox"/> |
| 8.  | Biographical Statement and Affidavits for ultimate parent(s) officers, directors and shareholders (including entities) owning 10% or more of parent company's stock.....                               | <input type="checkbox"/> |
|     | (a) No additional incorporators, officers, directors, and shareholders since approved in Application for Permit filing .....   | <input type="checkbox"/> |
|     | <b>or as to each biographical:</b>   |                          |
|     | (b) All information completed .....  | <input type="checkbox"/> |
|     | (c) Contains original signature .....  | <input type="checkbox"/> |
|     | (d) Notarized (original) .....   | <input type="checkbox"/> |
|     | (e) Original filed .....   | <input type="checkbox"/> |
| 9.  | Background investigative reports for the company incorporators, officers, directors and shareholders (including entities) owning 10% or more of applicant .....  | <input type="checkbox"/> |
|     | (a) No additional incorporators, officers, directors, and shareholders since approved in Application for Permit filing .....   | <input type="checkbox"/> |
| 10. | Background investigative reports for the immediate parent(s) officers, directors and shareholders (including entities) owning 10% or more of parent company's stock....                                | <input type="checkbox"/> |
|     | (a) No additional incorporators, officers, directors, and shareholders since approved in Application for Permit filing .....   | <input type="checkbox"/> |
| 11. | Background investigative reports for the ultimate parent(s) officers, directors and shareholders (including entities) owning 10% or more of parent company's stock....                                 | <input type="checkbox"/> |

- (a) No additional incorporators, officers, directors, and shareholders since approved in Application for Permit filing .....
12. Fingerprint cards enclosed for each company incorporator, officer, director and shareholder (including entities) owning 10% or more of applicant.....
- (a) No additional incorporators, officers, directors, and shareholders since approved in Application for Permit filing .....
- or as to each fingerprint card:**
- (b) Contains original signature.....
- (c) Florida cards only .....
- (d) All information completed (DOB, citizenship, vital statistics).....
13. Fingerprint cards enclosed for each immediate parent(s) officer, director and shareholder (including entities) owning 10% or more of parent company's stock .....
- (a) No additional incorporators, officers, directors, and shareholders since approved in Application for Permit filing .....
- or as to each fingerprint card:**
- (b) Contains original signature.....
- (c) Florida cards only .....
- (d) All information completed (DOB, citizenship, vital statistics).....
17. Fingerprint cards enclosed for each ultimate parent(s) officer, director and shareholder (including entities) owning 10% or more of parent company's stock .....
- (a) No additional incorporators, officers, directors, and shareholders since approved in Application for Permit filing .....
- or as to each fingerprint card:**
- (b) Contains original signature.....
- (c) Florida cards only .....
- (d) All information completed (DOB, citizenship, vital statistics).....

**THE COMPLETED CHECK LIST MUST BE RETURNED WITH THE APPLICATION PACKAGE.**

## CHECKLIST VERIFICATION

The undersigned says that he/she is a senior officer having personal knowledge of the application submitted to the Florida Office of Insurance Regulation in connection with licensure sought by (Entity Name) \_\_\_\_\_, that he/she has read said application, that he/she knows the contents thereof and verifies that the items indicated in the application checklist have been submitted with the application, that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument, the applicant on behalf which the person acted, executed the instrument.

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

Dated \_\_\_\_\_  
\_\_\_\_\_ (Give full and exact name of Applicant)

\_\_\_\_\_  
Signature of President, Secretary, or Treasurer

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Printed Title

**APPLICATION FOR DOMESTIC CERTIFICATE OF AUTHORITY TO CONDUCT BUSINESS  
IN THE STATE OF FLORIDA**

\_\_\_\_\_, 20 \_\_\_\_

TO THE FLORIDA OFFICE OF INSURANCE REGULATION,  
TALLAHASSEE, FLORIDA

The \_\_\_\_\_  
(Full name of company or association)

Type of Company: (for any type of property and casualty, title, life, and accident and health)

\_\_\_\_\_  
Federal Identification Number \_\_\_\_\_

Of \_\_\_\_\_  
(Home Office Address) (City) (State) (Zip)

Telephone Number: ( ) \_\_\_\_\_ - \_\_\_\_\_

through its duly authorized officers, hereby applies for a license authorizing and empowering the aforesaid Company or Association 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\_\_\_\_.

Lines of Business

Code Number

By \_\_\_\_\_  
President or Chief Executive Officer

(Corporate Seal)

Attest \_\_\_\_\_  
Secretary

# INVOICE

## OFFICE OF INSURANCE REGULATION DOMESTIC INSURER

### APPLICATION FOR CERTIFICATE OF AUTHORITY:

NAME OF COMPANY: \_\_\_\_\_

FEIN #: \_\_\_\_\_

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

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

PHONE NUMBER: (    ) \_\_\_\_\_ - \_\_\_\_\_

MAILING ADDRESS (IF DIFFERENT FROM STREET ADDRESS)

\_\_\_\_\_

\_\_\_\_\_ (CITY) (STATE) (ZIP CODE)

1. Make check 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 a copy of the check and the invoice along with the completed application package to the Florida Office of Insurance Regulation, Company Admissions, 200 E. Gaines Street, Larson Building, Tallahassee, Florida 32399-0332.

	B/T	TY/CL	F/T	AMOUNT
Company License Tax	C	10/30	L	\$1,000.00
Filing Fee	C	10/06	F	<u>\$1,500.00</u>
			Total	\$2,500.00

**DEPARTMENT OF FINANCIAL SERVICES  
OFFICE OF INSURANCE REGULATION  
LIFE, ACCIDENT AND HEALTH INSURERS  
LINES OF BUSINESS BY COMPANY CODE**

0400	Ordinary Life Endowment Term Life Industrial Life Individual Annuities Universal Life
0405	Individual Variable Annuities Group Variable Annuities
0410	Group Life and Annuities
0420	Variable Life
0425	Fraternal Life
0430	Fraternal Health
0440	Credit Life
0441	Credit Disability
0450	Accident and Health
R400	Reinsurance - Ordinary Life and Annuity
R405	Reinsurance - Individual/Group Variable Annuities
R410	Reinsurance - Group Life and Annuity
R420	Reinsurance - Variable Life
R440	Reinsurance - Credit Life
R441	Reinsurance - Credit Disability
R450	Reinsurance - Accident and Health

**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

# SERVICE OF PROCESS CONSENT & AGREEMENT

(Please type or print all information clearly)

Original Designation     Insurer Name Change     Merger / Acquisition     Update Delivery Information

Insurer or Company Name: \_\_\_\_\_

Previous Name (If applicable): \_\_\_\_\_

Home Office Address: \_\_\_\_\_

City, State, Zip \_\_\_\_\_

FEI # \_\_\_\_\_

FL Company Code \_\_\_\_\_

Telephone # \_\_\_\_\_

Know all men by these present, that the insurer or other entity named above is subject to the statutory agent for service of process provisions of the Florida Insurance Code duly organized and existing under and by virtue of the laws of the state of domicile.

Said entity does hereby agree and consent that actions may be commenced against it in any court having jurisdiction in 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. Said entity also hereby stipulates and agrees that any and all process so served shall be taken and held in all Courts to be as valid and binding upon this insurer or other entity as if personal service had been made upon the President or Secretary, or any other duly authorized and accredited officer thereof.

The undersigned hereby further agrees and stipulates that this agreement is and shall remain irrevocable, so long as there is liability, under any policy, claim or cause of action within this state, either fixed or contingent. Said insurer or other entity does hereby designate the following as the name and address of the person to whom all process is to be forwarded when process is served upon said Chief Financial Officer of the State of Florida on behalf of the above named insurer or entity. **In the event of a change in the name of the insurer or the designation of the person to whom process is to be forwarded, whether it be name, address, and/or phone or fax numbers, the insurer or company shall immediately file a new agreement form with the Chief Financial Officer of the State of Florida at the address shown at the bottom of this page.**

**Designated Person  
to receive process:** \_\_\_\_\_

**E-Mail Address:** \_\_\_\_\_

**Phone#:** \_\_\_\_\_ **Fax#:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

I hereby consent and agree to be the person to whom process served upon the Chief Financial Officer of the State of Florida for said entity, may be forwarded.

In Witness Whereof, we, the President or Chief Executive Officer and Secretary of said insurer or other entity, being duly authorized by the Board of Directors or governing body of this entity to execute this document, have hereunto set our hands and affixed the seal of said insurer or other entity on this the \_\_\_\_\_ day of \_\_\_\_\_, A.D. \_\_\_\_\_.

\_\_\_\_\_  
President or CEO's Signature

\_\_\_\_\_  
President or CEO's Name(Typed or Printed)

\_\_\_\_\_  
Secretary's Signature

\_\_\_\_\_  
Secretary's Name (Typed or Printed)

Any signatures other than the President, CEO, or Secretary for the Company must be validated by the attachment of a resolution of the Board of Directors or Governing body of said company delegating the authority to sign for the company.

SEAL

OIR-C1-144  
Rev 06/2004

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



**OFFICE OF INSURANCE REGULATION**  
**Company Admissions**

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

**REQUEST FOR PAYMENT OF FINGERPRINT CHARGES**

NAME OF COMPANY: \_\_\_\_\_

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

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

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

ADDRESS (IF DIFFERENT FROM COMPANY ADDRESS)

\_\_\_\_\_

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

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

**PLEASE NOTE:**

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

**B/T**  
**C**

**TY/CL**  
**1002**

**F/T**  
**F**

FEE SCHEDULE:

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

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



**OFFICE OF INSURANCE REGULATION**  
***Company Admissions***

---

**INSTRUCTIONS FOR FURNISHING BACKGROUND INVESTIGATIVE REPORTS**

1. A background investigative report must be completed for each individual as indicated in the instructions in the application package.
2. Please refer to the NAIC website at [http://www.naic.org/industry\\_ucaa.htm](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](mailto: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](mailto: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](mailto: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](http://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](http://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](mailto: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**

**DEPARTMENT OF FINANCIAL SERVICES  
OFFICE OF INSURANCE REGULATION  
CERTIFICATE OF DESIGNATION  
REGISTERED AGENT/REGISTERED OFFICE**

Pursuant to the provisions of Section 624.422, Florida Statutes, the undersigned corporation, organized under the laws of the State of Florida, submits the following statement in designating the registered office/registered agent, in the State of Florida.

1. The name of the corporation is: \_\_\_\_\_  
\_\_\_\_\_

2. The name and address of the registered agent and office is:  
\_\_\_\_\_  
(P.O. BOX NOT ACCEPTABLE)  
\_\_\_\_\_  
(CITY/STATE/ZIP)

SIGNATURE \_\_\_\_\_  
(corporate officer)

TITLE \_\_\_\_\_

DATE \_\_\_\_\_

HAVING BEEN NAMED TO ACCEPT SERVICE OF PROCESS FOR THE ABOVE STATED CORPORATION, AT THE PLACE DESIGNATED IN THIS CERTIFICATE, I HEREBY AGREE TO ACT IN THIS CAPACITY, AND I FURTHER AGREE TO COMPLY WITH THE PROVISIONS OF ALL STATUTES RELATIVE TO THE PROPER AND COMPLETE PERFORMANCE OF MY DUTIES, AND I ACCEPT THE DUTIES AND OBLIGATIONS OF SECTION 624.422, FLORIDA STATUTES.

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

**Office of Insurance Regulation  
INSURANCE HOLDING COMPANY SYSTEM  
REGISTRATION STATEMENT  
OF**

---

(State name of insurer)

and

---

---

---

(Name above all Florida domestic insurer members of the holding company system)

---

---

---

(Name above all admitted foreign insurer members of the holding company system)

Rule 4-143.046, Florida Administrative Code, requires that the registrant submit the following items to the Insurance Commissioner:

**ITEM I**

Describe the corporate and the capital structure of the insurer and all its affiliates. Attach financial statements if not incorporated by reference in accordance with rule 4-143.048.

**ITEM II**

Identify the ownership and management of the insurer and all of its affiliates; include each person who is directly or indirectly the beneficial owner of more than 10% of any class of any equity security or who is a director or officer of the insurer and any of its affiliates.

**ITEM III**

List all of the following agreements in force, relationships subsisting, and transactions currently outstanding between such insurer and its affiliates:

- (1) loans other investments, or purchases, sales or exchanges of securities of the affiliates by the insurer by its affiliates;
- (2) purchases, sales, or exchanges of assets;

**OIR-D0-516  
REV 4/97**



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

**INCORPORATORS:**

**TITLES:**

**OWNERSHIP PERCENTAGE:**

**OFFICERS:**

**DIRECTORS:**

**SHAREHOLDERS:**



DEPARTMENT OF FINANCIAL SERVICES  
OFFICE OF INSURANCE REGULATION

**INDIVIDUAL DISCLAIMER OF CONTROL AFFIDAVIT**

I, \_\_\_\_\_, the undersigned, do not and will not exercise any control, directly or indirectly, over the activities of the applicant (\_\_\_\_\_) or any entity owned or controlled by the applicant and licensed by the Office of Insurance Regulation. Further, I will not attempt to exercise any control, either directly or indirectly, over the activities of the applicant or any licensee without the advance written consent of the Office of Insurance Regulation.

I understand that pursuant to s. 837.06, Florida Statutes, knowingly making a false statement in writing with the intent to mislead a public servant in the performance of his official duty is a crime punishable as provided in s. 775.082 or s. 775.083, Florida Statutes. With this understanding, I knowingly make the above representation to the Office of Insurance Regulation.

\_\_\_\_\_  
(Signature)

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

BEFORE ME this day appeared \_\_\_\_\_ who, being duly sworn, deposes and says that he executed the above affidavit and that the statements and information contained therein are true and correct.

Sworn to as subscribed before me this \_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
(Notary Public)

My Commission expires: \_\_\_\_\_



DEPARTMENT OF FINANCIAL SERVICES  
OFFICE OF INSURANCE REGULATION

**DISCLAIMER OF CONTROL AFFIDAVIT**

I, \_\_\_\_\_, the undersigned, representing \_\_\_\_\_, certify that other than the following individuals:

- 1.
- 2.
- 3.
- 4.

no person in this company does or will exercise any control, directly or indirectly, over the activities of the applicant (\_\_\_\_\_) or any entity owned or controlled by the applicant and licensed by the Office of Insurance Regulation.

Further, no other person will attempt to exercise any control, either directly or indirectly, over the activities of the applicant or any licensee without the advance written consent of the Office of Insurance Regulation.

I understand that pursuant to s. 837.06, Florida Statutes, knowingly making a false statement in writing with the intent to mislead a public servant in the performance of his official duty is a crime punishable as provided in s. 775.082 or s. 775.083, Florida Statutes. With this understanding, I knowingly make the above representation to the Office of Insurance Regulation.

\_\_\_\_\_  
(Signature)

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

BEFORE ME this day appeared \_\_\_\_\_ who, being duly sworn, deposes and says that he executed the above affidavit and that the statements and information contained therein are true and correct.

Sworn to as subscribed before me this \_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
(Notary Public)

My Commission expires: \_\_\_\_\_



**OFFICE OF INSURANCE REGULATION**  
**Company Admissions**

Applicant Name (Company) \_\_\_\_\_

NAIC No. \_\_\_\_\_  
FEIN: \_\_\_\_\_

**BIOGRAPHICAL AFFIDAVIT**

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

**(Print or Type)**

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

1. Affiant's Full Name (Initials Not Acceptable). \_\_\_\_\_
2. a. Are you a citizen of the United States?  
b. Are you a citizen of any other country, if so, what country? \_\_\_\_\_
3. Affiant's Occupation or Profession. \_\_\_\_\_
4. Affiant's business address. \_\_\_\_\_  
Business telephone. \_\_\_\_\_
5. Education and Training:

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

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

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

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

Applicant Name (Company) \_\_\_\_\_

NAIC No. \_\_\_\_\_

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

6. List of memberships in professional societies and associations.

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

7. Present or proposed position with the applicant entity. \_\_\_\_\_  
\_\_\_\_\_

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

Beginning/Ending  
 Dates (MM/YY) \_\_\_\_\_ - \_\_\_\_\_ Employer's Name \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State/Province \_\_\_\_\_  
 Country \_\_\_\_\_ Postal Code \_\_\_\_\_ Phone \_\_\_\_\_ Offices/Positions Held \_\_\_\_\_  
 Supervisor / Contact \_\_\_\_\_

Beginning/Ending  
 Dates (MM/YY) \_\_\_\_\_ - \_\_\_\_\_ Employer's Name \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State/Province \_\_\_\_\_  
 Country \_\_\_\_\_ Postal Code \_\_\_\_\_ Phone \_\_\_\_\_ Offices/Positions Held \_\_\_\_\_  
 Supervisor / Contact \_\_\_\_\_

Beginning/Ending  
 Dates (MM/YY) \_\_\_\_\_ - \_\_\_\_\_ Employer's Name \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State/Province \_\_\_\_\_  
 Country \_\_\_\_\_ Postal Code \_\_\_\_\_ Phone \_\_\_\_\_ Offices/Positions Held \_\_\_\_\_  
 Supervisor / Contact \_\_\_\_\_

Beginning/Ending  
 Dates (MM/YY) \_\_\_\_\_ - \_\_\_\_\_ Employer's Name \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State/Province \_\_\_\_\_  
 Country \_\_\_\_\_ Postal Code \_\_\_\_\_ Phone \_\_\_\_\_ Offices/Positions Held \_\_\_\_\_

Applicant Name (Company) \_\_\_\_\_

NAIC No. \_\_\_\_\_

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

Supervisor / Contact \_\_\_\_\_

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

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

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

Organization/Issuer of License \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_ Country \_\_\_\_\_ Postal Code \_\_\_\_\_

License Type \_\_\_\_\_ License # \_\_\_\_\_ Date Issued (MM/YY) \_\_\_\_\_

Date Expired (MM/YY) \_\_\_\_\_ Reason for Termination \_\_\_\_\_

Non-insurance Regulatory Phone Number (if known) \_\_\_\_\_

Organization /Issuer of License \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_ Country \_\_\_\_\_ Postal Code \_\_\_\_\_

License Type \_\_\_\_\_ License # \_\_\_\_\_ Date Issued (MM/YY) \_\_\_\_\_

Date Expired (MM/YY) \_\_\_\_\_ Reason for Termination \_\_\_\_\_

Non-insurance Regulatory Phone Number (if known) \_\_\_\_\_

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

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

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

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

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

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

\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

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

Applicant Name (Company) \_\_\_\_\_

NAIC No. \_\_\_\_\_

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

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

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

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

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

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

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

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

\_\_\_\_\_  
(Signature of Affiant)

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

The foregoing instrument was acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ By

\_\_\_\_\_, and:

who is personally known to me, or

who produced the following identification: \_\_\_\_\_

[SEAL]

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

\_\_\_\_\_  
Printed Notary Name

\_\_\_\_\_  
My Commission Expires



**OFFICE OF INSURANCE REGULATION**  
**Company Admissions**

Applicant Name (Company) \_\_\_\_\_

NAIC No. \_\_\_\_\_  
FEIN: \_\_\_\_\_

**BIOGRAPHICAL AFFIDAVIT**  
**Supplemental Personal Information**

**(Print or Type)**

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

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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

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

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

Applicant Name (Company) \_\_\_\_\_

NAIC No. \_\_\_\_\_  
FEIN: \_\_\_\_\_

5. Foreign Student ID# (if applicable) \_\_\_\_\_

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

7 Name of Affiant's Spouse (if applicable) \_\_\_\_\_

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

Beginning/Ending

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

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

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

\_\_\_\_\_  
(Signature of Affiant)

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

The foregoing instrument was acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ By \_\_\_\_\_, and:

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

[SEAL]

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

\_\_\_\_\_  
Printed Notary Name

\_\_\_\_\_  
My Commission Expires

Applicant Name (Company) \_\_\_\_\_

NAIC No. \_\_\_\_\_

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

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

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

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

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

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

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

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

\_\_\_\_\_  
(Printed Full Name and Residence Address)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

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

The foregoing instrument was acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_ By \_\_\_\_\_, and

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

[SEAL]

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

\_\_\_\_\_  
Printed Notary Name

\_\_\_\_\_  
My Commission Expires

Applicant Name (Company) \_\_\_\_\_

NAIC No. \_\_\_\_\_

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

**DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS (Minnesota and Oklahoma)**

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

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

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

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

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

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

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

\_\_\_\_\_  
(Printed Full Name and Residence Address)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

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

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

who is personally known to me, or

who produced the following identification: \_\_\_\_\_

[SEAL]

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

\_\_\_\_\_  
Printed Notary Name

\_\_\_\_\_  
My Commission Expires

Applicant Name (Company) \_\_\_\_\_

NAIC No. \_\_\_\_\_

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

**DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS (California)**

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

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

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

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

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

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

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

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

\_\_\_\_\_  
(Printed Full Name and Residence Address)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

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

The foregoing instrument was acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ By \_\_\_\_\_, and

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

[SEAL]

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

\_\_\_\_\_  
Printed Notary Name

\_\_\_\_\_  
My Commission Expires