



**Office of Insurance Regulation**  
*Company Admissions*

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**APPLICATION FOR REGISTRATION AS A FISCAL INTERMEDIARY SERVICES ORGANIZATION**

This package has been developed to aid you in notifying the Office of Insurance Regulation of your intention to act as a fiscal intermediary services organization in Florida under the provisions of Section 641.316, Florida Statutes.

In order to register with the Office of Insurance Regulation, a fiscal intermediary must:

- (1) Complete and file the attached Application For Registration as a Fiscal Intermediary Services Organization and Addendum. Please fill these forms out completely. The Office of Insurance Regulation's qualification of your fiscal intermediary services organization registration under Section 641.316(6), Florida Statutes will be delayed until a fully completed registration package is received.
- (2) Provide a written statement indicating that the proposed organization will not be billing for or collecting premium on behalf of any entity.
- (3) Registration Requirements

Pursuant to Section 641.316(3), Florida Statutes, a fiscal intermediary services organization shall be required to secure and maintain a fidelity bond in the minimum amount of 10 percent of the funds handled by the intermediary in connection with its fiscal and fiduciary services during the prior year or \$1 million, whichever is less. The minimum bond amount shall be \$50,000. The fidelity bond shall protect the fiscal intermediary from loss caused by the dishonesty of its employees and must remain unimpaired for as long as the intermediary continues in business in the state.

Pursuant to F.S. 641.316(4), Florida Statutes, a fiscal intermediary services organization shall secure and maintain a surety bond on file with the Office, naming the intermediary as principal. The bond must be obtained from a company authorized to write surety insurance in the state, and the Office shall be obligee on behalf of itself and third parties. The penal sum of the bond may not be less than 5 percent of the funds handled by the intermediary in connection with its fiscal and fiduciary services during the prior year or \$250,000, whichever is less. The minimum bond amount must be \$10,000. The condition of the bond must be that the intermediary shall register with the Office and shall not misappropriate funds within its control or custody as a fiscal intermediary or fiduciary.

## APPLICATION FOR REGISTRATION AS A FISCAL INTERMEDIARY SERVICES ORGANIZATION

The following requirements pertain to each officer, director, and owners of excess of 5 percent of the common stock of the organization, or other persons responsible for the conduct and affairs of the organization.

(a) Biographical Statement and Affidavit

The Office of Insurance Regulation's forms are enclosed with this package and must be used. Submit the original of each form.

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.

(b) Background Investigative Report

Provide a background investigative report for each individual as indicated 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 form OIR-C1-905 for instructions.

(c) Fingerprint Cards

Fingerprint cards must be completed for each individual as indicated above. 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.

All questions regarding Fiscal Intermediary Services Organizations and their operation in Florida should be directed to the Life and Health Financial Oversight area at (850) 413-3155. Applications should be mailed to:

Office of Insurance Regulation  
Company Admissions  
200 East Gaines Street  
Tallahassee, Florida 32399-0332

**AFTER REVIEW OF ALL DOCUMENTS, YOU WILL RECEIVE A WRITTEN RESPONSE FROM THE OFFICE OF INSURANCE REGULATION WHEN THE FISCAL INTERMEDIARY SERVICES ORGANIZATION IS PROPERLY REGISTERED.**

**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 REGISTRATION AS A FISCAL INTERMEDIARY SERVICES ORGANIZATION**

(Please type all information.)

1. List the name of the Fiscal Intermediary Services Organization:

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2. Indicate the form of organization (i.e. corporation, partnership, etc.)

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3. Provide a copy of the organizational chart.

4. Provide the name of the domiciliary state:

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5. List any other names under which the Fiscal Intermediary Services Organization is or may be doing business in this state or any other state if different than above.

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6. List the complete physical address of the Fiscal Intermediary Services Organization.

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7. List the name, title, address and telephone number of each officer/director of the Fiscal Intermediary Services Organization and the key officer or staff person responsible for overseeing operations of the group. (Attach additional pages if necessary.)

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## **APPLICATION FOR REGISTRATION AS A FISCAL INTERMEDIARY SERVICES ORGANIZATION**

8. Submit a business plan to include a description of the services to be performed by the Fiscal Intermediary Services Organization (FISO), the entities with which the FISO will be contracting, and the amount of funds estimated to be handled by the FISO.
9. Submit a sample contract that the FISO intends to use if plans are to use another rather than the HMO provider contract.
10. Provide a copy of the executed fidelity bond pursuant to Section 641.316(3), Florida Statutes.

Section 641.316(3), Florida Statutes indicates:

“A fiscal intermediary services organization that is operated for the purpose of acquiring and administering provider contracts with managed care plans for professional health care services, including, but not limited to, medical, surgical, chiropractic, dental, and podiatry care, and which performs fiduciary or fiscal intermediary services shall be required to secure and maintain a fidelity bond in the minimum amount of 10 percent of the funds handled by the intermediary in connection with its fiscal and fiduciary services during the prior year or \$1 million, whichever is less. The minimum bond amount shall be \$50,000. The fidelity bond shall protect the fiscal intermediary from loss caused by the dishonesty of its employees and must remain unimpaired for as long as the intermediary continues in business in the state.”

The fidelity bond should include: the name of both the insurer and the insured; a description of the bond; and the amount and term of the bond. In addition, the Office of Insurance Regulation should be included as an additional insured for purposes of notification of termination. This notification should provide the Office of Insurance Regulation at least 30 days advance written notification of the termination.

11. Provide a copy of the executed surety bond on the Office of Insurance Regulation approved bond form pursuant to Section 641.316(4), Florida Statutes.

Section 641.316(4), Florida Statutes indicates:

“A fiscal intermediary services organization...shall secure and maintain a surety bond on file with the Office of Insurance Regulation, naming the intermediary as principal. The bond must be obtained from a company authorized to write surety insurance in the state, and the Office of Insurance Regulation shall be obligee on behalf of itself and third parties. The penal sum of the bond may not be less than 5 percent of the funds handled by the intermediary in connection with its fiscal and fiduciary services during the prior year or \$250,000, whichever is less. The minimum bond amount must be \$10,000. The condition of the bond must be that the intermediary shall register with the Office of Insurance Regulation and shall not misappropriate funds within its control or custody as a fiscal intermediary or fiduciary. The aggregate liability of the surety for any and all breaches of the conditions of the bond may not exceed the penal sum of the bond. The bond must be continuous in form, must be renewed annually by the surety upon its giving 30 days' written notice of termination to the Office of Insurance Regulation.”

**APPLICATION FOR REGISTRATION AS A FISCAL INTERMEDIARY SERVICES ORGANIZATION**

The surety bond should include: the name of both the insurer and the insured; a description of the bond; and the amount and term of the bond. In addition, the Office of Insurance Regulation should be included as an additional insured for purposes of notification of termination. This notification should provide the Office of Insurance Regulation at least 30 days advance written notification of the termination.

We do hereby swear and affirm that the aforementioned statements and information are true and correct.

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

\_\_\_\_\_  
Secretary

Sworn before me this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
NOTARY PUBLIC

State of:

My Commission Expires:

**APPLICATION FOR REGISTRATION AS A FISCAL INTERMEDIARY SERVICES ORGANIZATION**

**State of Florida  
Office of Insurance Regulation  
200 E. Gaines Street  
Tallahassee, Florida 32399-0319**

**FISCAL INTERMEDIARY SURETY BOND**

Bond # \_\_\_\_\_

KNOW ALL MEN BY THESE PRESENTS,  
that \_\_\_\_\_, fiscal intermediary services organization,  
which place of business is \_\_\_\_\_, Florida as  
Principal, and \_\_\_\_\_ as Surety are held and  
firmly bound unto THE OFFICE OF INSURANCE REGULATION, as Obligee, or its successors  
in office, in the penal sum of \_\_\_\_\_ Thousand dollars (\$) [not less  
than \$ 10,000.00], in the lawful money of the United States of America, for payment of which  
well and truly to be made, we bind ourselves, and our and each of our heirs, executors,  
administrators, successors and assigns jointly and severally, firmly by these presents:

THE CONDITIONS OF THIS OBLIGATION ARE SUCH THAT the Principal, the above bounden  
\_\_\_\_\_ shall faithfully comply with and conduct business in  
accordance with the provisions of the fiscal intermediary services law, Section 641.316(4)  
Florida Statutes, and abide by all applicable rules and regulations of the OFFICE OF  
INSURANCE REGULATION as promulgated by the DIRECTOR OF OFFICE OF INSURANCE  
REGULATION. However, nothing in this bond shall be construed to require the surety to  
provide coverage or otherwise indemnify the Obligee for any violations of any applicable  
statutes, rules or regulations except as specifically provided below.

This bond shall be in favor of the OFFICE OF INSURANCE REGULATION as the obligee, shall  
be registered with the OFFICE OF INSURANCE REGULATION and shall specifically authorize  
recovery by the OFFICE OF INSURANCE REGULATION of the damages sustained in case the  
principal or its officers, agents, or employees misappropriate funds within its control or custody  
as a fiscal intermediary or fiduciary.

THE SURETY BOND SHALL PROVIDE coverage to the OFFICE OF INSURANCE  
REGULATION only against loss caused by the dishonesty of the fiscal intermediary or its  
officers, employees and agents and must remain in force for as long as the fiscal intermediary  
does business in this state.

**APPLICATION FOR REGISTRATION AS A FISCAL INTERMEDIARY SERVICES  
ORGANIZATION**

**FISCAL INTERMEDIARY SURETY BOND**

IT IS MUTUALLY AGREED AND UNDERSTOOD BETWEEN ALL PARTIES HERETO, that if the Surety shall so elect, this bond may be canceled and discontinued by giving thirty (30) days notice in writing to the Principal and filed with THE OFFICE OF INSURANCE REGULATION, or its successors in office, by United States Registered Mail and this Bond shall be deemed canceled at the expiration of the thirty (30) days from the receipt of said notice, the surety remaining liable for all obligations covered by this bond, which may have accrued by default of the Principal prior to the effective date of the cancellation.

IN WITNESS WHEREOF the said Principal has caused these presents to be executed by affixing thereto his or her signature, and the said surety has caused presents to be executed by the signature of its attorney in fact and its corporate seal to be affixed hereto attested by its attorney in fact this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_. This bond shall become effective on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, and remain in force until canceled.

\_\_\_\_\_  
Principal

\_\_\_\_\_  
Surety (Name of Insurance Company)

\_\_\_\_\_  
Witness to Principal

\_\_\_\_\_  
Attorney in Fact (signature)

# 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***

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**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**



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

Applicant Name \_\_\_\_\_

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. a. Affiant's Full Name (Initials Not Acceptable). \_\_\_\_\_

b. Maiden Name (if applicable). \_\_\_\_\_

2. a. Have you ever had your name changed? \_\_\_\_\_ If yes, give the reason for the change and provide the full name(s).

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

b. Other names used at any time (including aliases).

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

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

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

4. Affiant's Occupation or Profession. \_\_\_\_\_

5. Affiant's business address. \_\_\_\_\_

Business telephone. \_\_\_\_\_



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

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

10. 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. \_\_\_\_\_

11. 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. 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) \_\_\_\_\_

12. 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.

\_\_\_\_\_

\_\_\_\_\_

13. 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. \_\_\_\_\_

14. 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.

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

16. 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) 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

**BIOGRAPHICAL AFFIDAVIT**  
**Supplemental 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).

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1. a. Affiant's Full Name (Initials Not Acceptable). \_\_\_\_\_  
b. Maiden Name (if applicable) \_\_\_\_\_
2. Affiant's Social Security Number \_\_\_\_\_
3. Government Identification Number if not a U.S. Citizen \_\_\_\_\_
4. Foreign Student ID# (if applicable) \_\_\_\_\_
5. Date of Birth: (MM/DD/YY) \_\_\_\_\_ Place of Birth: City \_\_\_\_\_  
State/Province \_\_\_\_\_ Country \_\_\_\_\_
6. Name of Affiant's Spouse (if applicable) \_\_\_\_\_
7. 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

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)

\_\_\_\_\_  
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

**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

**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

**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