



OFFICE OF INSURANCE REGULATION

Company Admissions

**APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION**

The Health Maintenance Organization's Application for Certificate of Authority requires five (5) categories of information:

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

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

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

Submit the completed application package to:

Florida 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
HEALTH MAINTENANCE ORGANIZATION**

Pursuant to Section 641.2015 and 641.19, Florida Statutes, in order to qualify as a Health Maintenance Organization, an entity must:

- A. Be incorporated or be a division of a corporation formed under the provisions of either chapter 607 or Chapter 617, or shall be a public entity that is organized as a political subdivision. [s. 641.2015, F.S.];
- B. Provide emergency care, inpatient hospital services, physician care including care provided by physicians licensed under Chapters 458, 459, 460, and 461, ambulatory diagnostic treatment, and preventive health care services. [s.641.19(12)(a), F.S.];
- C. Provide either directly or through arrangements with other persons, health care services to persons enrolled with such organization, on a prepaid per capita or prepaid aggregate fixed-sum basis. [s.641.19(12)(b), F.S.];
- D. Provide either directly or through arrangements with other persons, comprehensive health care services which subscribers are entitled to receive pursuant to a contract. [s.641.19(12)(c), F.S.];
- E. Provide physician services, by physicians licensed under Chapters 458, 459, 460 and 461, directly through physicians who are either employees or partners of such organization or under arrangements with a physician or any group of physicians. [s.641.19(12)(d),F.S.]; and
- F. If an HMO offers services through a managed care system, then the managed care system must be a system in which a primary physician licensed under chapter 458 or Chapter 459 and Chapters 460 and 461 is designated for each subscriber upon request of a subscriber requesting service by a physician licensed under any of those chapters, and is responsible for coordinating the health care of the subscriber of the respectively requested service and for referring the subscriber to other providers of the same discipline when necessary. Each female subscriber may select as her primary physician an obstetrician/gynecologist who has agreed to serve as a primary physician and is in the health maintenance organization's provider network [s.641.19(12)(e), F.S.]

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

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

Section I-11 Application Fee

The application filing fee is \$1,000. [s.641.29(1),F.S.]

Secure the check to the invoice, which is included in this package, and send to:

Department of Financial Services
Bureau of Financial Services
PO Box 6100
Tallahassee, Florida 32301-0315

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

Section I-2 Fingerprint Processing Fees

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

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

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

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

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Section I-3 Deposits and Assessments

- A. Submit a check for \$10,000 made payable to " Director of Insurance Regulation, State of Florida-Rehabilitation Administrative Expense Fund" to comply with Section 641.227(1), Florida Statutes. Mail the check to:

Department of Financial Services
Revenue Processing Section
PO Box 6100
Tallahassee, Florida 32314-6100

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

- B. Submit a check for \$25,000 made payable to "Florida HMO Consumer Assistance Plan" to cover the special assessment required by Section 641.228(1), Florida Statutes. Mail the check to:

Bruce D. Platt, Plan Manager
Suite 1200, 106 East College Avenue
Tallahassee, FL 32301
(850) 425-1628

Place a photocopy of your transmittal letter to the Plan Manager and the check in this section.

Section I-4 Application for Certificate of Authority (Official Form Attached)

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

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SECTION II - LEGAL

Section II-1 Articles of Incorporation

Submit Articles of Incorporation and all amendments certified by the Florida Secretary of State's office. The certification must be an original.

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

Submit an original certificate of status by the Florida Secretary of State's office demonstrating that the company is in good standing. You may contact the Florida Secretary of State's office at (850) 245-6052 for further information in obtaining this certificate.

Section II-3 Company Bylaws

Submit a copy of the company's bylaws, rules and regulations or similar form of document, if any, regulating the conduct of the affairs of the applicant. These documents must be accompanied by a Board Resolution signed and dated by the secretary of the corporation, stating that the documents are a true and correct copy. The signature must be original and under the company's corporate seal.

Section II-4 Health Care Provider Certificate

Submit documentation demonstrating that the entity has filed an application for a Health Care Provider Certificate to be issued by the Agency for Health Care Administration (AHCA) pursuant to Chapter 641, Part III, Florida Statutes. Documentation may be provided in the form of an acknowledgement from the Agency for Health Care that the application has been received by them.

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

Section II-5 Authorization Letter

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

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SECTION III - FINANCIAL AND RELATED INFORMATION

Section III-1 Insurance

- A. Furnish evidence of adequate insurance coverage or an adequate plan for self-insurance to respond to claims for injuries arising from the provision of health care services. If not self-insured, submit executed copies of the following policies, with the Office of Insurance Regulation listed on the policies for purposes of notification of any modification, cancellation or termination of the policies:
- (1) General liability
 - (2) Medical malpractice or professional liability. The HMO must secure this coverage. The fact that the medical provider has this coverage does not release the HMO from the obligation to secure it. A binder for the policies along with a specimen copy of each policy can be submitted initially. Prior to licensure, executed copies of the policies must be submitted.
- B. Furnish a photocopy of an executed fidelity bond in the minimum amount of \$100,000, issued by an **authorized insurance carrier** in this State and covering all employees handling funds.
- C. Describe how the HMO limits or proposes to limit its financial risk. If the HMO secures catastrophic or reinsurance coverage, it is required to submit executed copies of the applicable policy with the Office of Insurance Regulation. Any reinsurance agreement must comply with Section 624.610, Florida Statutes and Rule 69O-144, Florida Administrative Code.

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

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Section III-2 Financial Statements

- A. Provide a copy of the most recent audited certified public accountant's report prepared on the basis of statutory accounting principles. If the applicant is a development stage company that has not begun operations, an audited balance sheet should be provided. The financial statements should reflect sufficient surplus to meet the requirements of s. 641.225, Florida Statutes.

- B. Provide all quarterly financial statements covering the current year-to-date reporting period signed by the company's officers under notary seal.

Section III-3 Plan of Operations

Provide a statement generally describing present and proposed operations. State whether the HMO will be organized for profit or not for profit and whether it will be a Staff Model, IPA Model, or Combination Model HMO. Also, identify the HMOs fiscal year end date. The plan of operations should be for the greater of three years or until the health maintenance organization has been projected to be profitable for twelve consecutive months.

If the HMO intends to market to small groups as defined by the Employee Health Care Access Act, s. 627.6699, Florida Statutes, please complete and submit the attached small employer carrier's application.

If the plan of operation indicates that the HMO will receive Medicaid funds, list all contracts and agreements and any information relative to any payment or agreement to pay, directly or indirectly, a consultant fee, a broker fee, a commission, or other fee or charge related in any way to the application for a certificate of authority or the issuance of a certificate authority. Such list shall provide the following, including, but not limited to, the name of the person or entity paying the fee; the name of the person or entity receiving the fee; the date of payment; and a brief description of the work performed.

Section III-3(a) Marketing and Growth

Submit a description of the proposed method of marketing, including the target groups, types of coverage to be offered, and advertising media to be used. Include a statement describing with reasonable certainty the geographic area or areas to be served by the HMO. Identify competing HMOs operating in the same geographic service area, as well as the market penetration of each. Also, identify the major differences between the applicant HMO and its competitors.

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Section III-3(b) Pro Forma Statements

Submit a pro forma balance sheet and income statement on a statutory basis at monthly intervals (with an annual total) for a minimum three-year period (greater of three years or until the health maintenance organization has been projected to be profitable for twelve consecutive months.) All assumptions used in deriving the pro forma statements must be provided. A Statement of Changes in Financial Position and a Statement of Cash Flows should be provided for the three-year period (or break-even), as well.

Section III-3(c) Statement of Initial Cash

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

Section III-3(d) History

Provide a brief history of the company since its incorporation. Include any predecessor corporations or organizations, mergers, reorganizations, or changes of ownership. Specify the parties and dates involved.

Section III-3(e) Insolvency Protection

Provide the method in which the applicant will comply with the insolvency protection requirements of Section 641.285, Florida Statutes, including all relevant documentation necessary to meet the requirements. Each HMO must comply with the insolvency protection requirements of Florida law. This is accomplished through a deposit with the Office of Insurance Regulation in the amount of \$300,000.00.

Section III-3(f) Contingency Plans

Provide any contingency plans for additional capital should the HMO fail to maintain minimum surplus requirements as mandated by Section 641.225, Florida Statutes.

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Section III-3(g) Feasibility Study

Submit a comprehensive feasibility study, performed by a certified actuary in conjunction with a certified public accountant, which includes a rate and financial analysis, as well as enrollment projections and assumptions and competitor information. The study shall be for the greater of three years or until the HMO has been projected to be profitable for twelve consecutive months. The study shall show that the HMO will maintain, at all times, the minimum surplus required by Section 641.225, Florida Statutes, and will not, at the end of any month of the projection period, have less than the minimum surplus as required by Section 641.225, Florida Statutes. The feasibility study shall contain an opinion by the CPA and actuary performing the study which shall opine as to the reasonableness of the assumptions used in the feasibility study and that the assumptions are reasonably applied.

The financial portion of the study shall be prepared in accordance with standards promulgated by the American Institute of Certified Public Accountants in its "Guide for Prospective Financial Statements" and opined accordingly. The actuarial portion of the study shall be prepared in accordance with standards promulgated by the American Academy of Actuaries and opined accordingly. The feasibility study shall contain nothing less than an "examination opinion."

Section III-4 Contracts

- A. A copy of each type of contract made, or to be made, between the applicant and any providers (i.e hospitals, physicians, physician groups) regarding the provision of health care services to enrollees. All such contracts shall comply with Section 641.315, Florida Statutes.
- B. A copy of the form of any contract made or to be made between the applicant and senior management employment, as well as any person, corporation, partnership, or other entity for the performance on the applicant's behalf of any function including, but not limited to, marketing, administration, enrollment, investment management, and subcontracting for the provision of health care services to enrollees. All such contracts shall comply with Section 641.234, Florida Statutes and 641.315, F.S. if applicable.

Section III-5 Grievance Procedure

A statement describing the HMO's grievance procedure that will facilitate the resolution of subscriber grievances. The grievance procedure must include both formal and informal steps for resolving grievances and must be in compliance with all requirements set forth in Rule 4-191.078 (1 - 12), F.A.C., s.641.21(1)(e), & s. 641.22(9), F.S.

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Section III-6 Bankruptcy Proceedings

Submit evidence of compliance with Section 641.215, Florida Statutes. This documentation should contain:

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

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SECTION IV - MANAGEMENT

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

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

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

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

Provide a Biographical Affidavit (Form OIR-C1-1423) for each officer, director, and shareholder listed in Section IV-1 except for those companies in the organizational structure between the immediate parent and the ultimate parent. All questions must be answered.

The requirements 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 Biographical affidavit, please include the affiant's name and social security on a separate page and attach it to the Biographical Affidavit. Also please stamp CONFIDENTIAL at the top and bottom of the separate page.

Section 119.071(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.

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Section IV-3 Authority for Release of Information

Provide an Authority for Release of Information form (page 8 of Form OIR-C1-1423) for each person listed in Section IV-1 except for those companies in the organizational structure between the immediate parent and the ultimate parent. Each form must contain an original signature and an original notary seal.

Section IV-4 Investigative Background Reports

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

Section IV-5 Fingerprint Cards

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

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

Please place the completed fingerprint cards in this section.

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

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SECTION V - FORMS AND RATES

Note: submit three (3) original copies of each referenced form and rate filing.

Section V-1 **Forms**

- A. Submit three copies of each policy, master contract, certificate of coverage, member handbook, application, or any other form the applicant proposes to offer the subscriber. This includes any form showing the benefits to which the subscriber is entitled and any form used in the enrollment process. Every form which the HMO will use in connection with its subscriber contracts must be submitted and must be identified by a unique form number located on the lower left corner of the form.

- B. Each subscriber contract must state the procedures for offering comprehensive health care services and offering and terminating contracts to subscribers which will not unfairly discriminate on the basis of age, sex, race, handicap, health, or economic status.

Section V-2 **Rates**

- A. Submit three copies of the complete schedule of proposed premium rates for each type of contract. The submission for each separate contract should contain an opinion from a qualified independent actuary. The opinion shall:
 - (1) Certify that the rates are neither inadequate nor excessive nor unfairly discriminatory;
 - (2) Certify that the rates are appropriate for the classes or risks for which they have been computed;
 - (3) Present an adequate description of the rating methodology, following consistent and equitable actuarial principles.

- B. Furnish a statement from a qualified independent actuary that the HMO is actuarially sound.

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

Company Name: _____

<u>Item #</u>		<u>Completion Check List</u>
1.	Application Fees Paid	<input type="checkbox"/>
	(a) Copy of invoice included (Official Form)	<input type="checkbox"/>
	(b) Copy of check included	<input type="checkbox"/>
	(c) Check mailed to address on Invoice	<input type="checkbox"/>
2.	Fingerprint fee paid electronically	<input type="checkbox"/>
	(a) Copy of on-line payment confirmation	<input type="checkbox"/>
	or, if applicable	
	(b) Copy of invoice included (Official Form)	<input type="checkbox"/>
	(b) Copy of check included	<input type="checkbox"/>
	(c) Check mailed to address on Invoice	<input type="checkbox"/>
3.	Deposits and Assessments	<input type="checkbox"/>
	(a) Copy of \$10,000 check and copy of Invoice	<input type="checkbox"/>
	(b) Copy of \$25,000 check and copy of cover letter	<input type="checkbox"/>
4.	Application for Certificate of Authority (Official Form)	<input type="checkbox"/>
	(a) Application form completed	<input type="checkbox"/>
	(b) Sealed by corporation	<input type="checkbox"/>

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<u>Item #</u>		<u>Completion Check List</u>
(c)	Signed by President and other authorized officer (original signature)	<input type="checkbox"/>
(d)	Notarized	<input type="checkbox"/>

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SECTION II - LEGAL

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

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SECTION III - FINANCIAL AND RELATED INFORMATION

<u>Item #</u>		<u>Completion Check List</u>
1.	Insurance	<input type="checkbox"/>
	(a) Copy of current general liability policy or plan for self-insurance	<input type="checkbox"/>
	and Current medical malpractice policy or plan for self-insurance	<input type="checkbox"/>
	(b) Evidence of current fidelity bond	<input type="checkbox"/>
	(c) Reinsurance treaty	<input type="checkbox"/>
2.	Financial Statements	<input type="checkbox"/>
	(a) Current audited financial statements	<input type="checkbox"/>
	(b) Quarterly financial statement	<input type="checkbox"/>
3.	Plan of Operations	<input type="checkbox"/>
	(Small Employer Carrier Application, if applicable)	<input type="checkbox"/>
	(a) Marketing and Growth	<input type="checkbox"/>
	(1) Description of marketing methods	<input type="checkbox"/>
	(2) A statement describing the applicant, facilities and personnel, etc	<input type="checkbox"/>
	(3) Statement of geographic area to be served	<input type="checkbox"/>

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<u>Item #</u>	<u>Completion Check List</u>
(b) Pro Forma Statements	<input type="checkbox"/>
(1) Balance sheet	<input type="checkbox"/>
(2) Income statement	<input type="checkbox"/>
(3) Cash flow analysis	<input type="checkbox"/>
(4) Change in financial position	<input type="checkbox"/>
(c) Statement of Initial Cash	<input type="checkbox"/>
Provisions for contingencies	<input type="checkbox"/>
(d) History	<input type="checkbox"/>
(e) Insolvency Protection Deposit with the Office	<input type="checkbox"/>
(1) Deposit with the Office	<input type="checkbox"/>
or	
(2) Reinsurance Policy	<input type="checkbox"/>
or	
(3) Guarantee Arrangement	<input type="checkbox"/>
(f) Contingency Plans	<input type="checkbox"/>
(g) Feasibility study	<input type="checkbox"/>
4. Contracts	<input type="checkbox"/>
(a) Provider contract form and signature pages	<input type="checkbox"/>
(b) Other forms of contracts	<input type="checkbox"/>

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<u>Item #</u>		<u>Completion Check List</u>
5.	Grievance Procedure	<input type="checkbox"/>
	(a) Formal and informal steps included	<input type="checkbox"/>
6.	Bankruptcy Proceedings	<input type="checkbox"/>
	(a) Acknowledgement filed	<input type="checkbox"/>
	(b) Waiver for bankruptcy proceeding	<input type="checkbox"/>
	(c) Acknowledgement for bankruptcy proceeding	<input type="checkbox"/>

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SECTION IV - MANAGEMENT

<u>Item #</u>	<u>Completion Check List</u>
1. Listing of all officers, directors, and shareholders (including entities owning 5% or more of applicant (Form OIR-C1-1432).	<input type="checkbox"/>
2. Listing of all immediate parent(s) officers, directors and shareholders (including entities) owning 5% or more of parent company's stock (Form OIR-C1-1432).....	<input type="checkbox"/>
3. Listing of all intermediary parent(s) (between immediate parent(s) and ultimate parent(s)), officers and shareholders (including entities) owning 5% or more of parent company's stock (Form OIR-C1-1432). Note, do not complete Form OIR-C1-1423 (Biographical Affidavits), or order investigative reports or fingerprint cards.....	<input type="checkbox"/>
4. Listing of all ultimate parent(s) officers, directors and shareholders (including entities) owning 5% or more of parent company's stock (Form OIR-C1-1432)	<input type="checkbox"/>
5. Organizational Chart including all entities within the ultimate parent company structure	<input type="checkbox"/>
6. Biographical Affidavits for company officers, directors and shareholders (including entities) owning 5% or more of applicant (Form OIR-C1-1423)	<input type="checkbox"/>
As to each biographical:	
(a) All blanks completed	<input type="checkbox"/>
(b) "Yes" answers explained	<input type="checkbox"/>
(c) Contains original signature	<input type="checkbox"/>
(d) Notarized (original)	<input type="checkbox"/>
(e) Original of each affidavit submitted.....	<input type="checkbox"/>
(f) SSN on a separate page	<input type="checkbox"/>

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<u>Item #</u>	<u>Completion Check List</u>
7.	Biographical Affidavits for immediate parent(s) officers, directors and shareholders (including entities) owning 5% or more of parent Company's stock (Form OIR-C1-1423)..... <input type="checkbox"/>
	As to each biographical:
(a)	All blanks completed <input type="checkbox"/>
(b)	"Yes" answers explained <input type="checkbox"/>
(c)	Contains original signature <input type="checkbox"/>
(d)	Notarized (original) <input type="checkbox"/>
(e)	Original and one copy of each affidavit submitted <input type="checkbox"/>
(f)	SSN on a separate page..... <input type="checkbox"/>
8.	Biographical Affidavits for ultimate parent(s) officers, directors and Shareholders (including entities) owning 5% or more of parent company's Stock (Form OIR-C1-1423, REV 5/02)
	As to each biographical:
(a)	All blanks completed <input type="checkbox"/>
(b)	"Yes" answers explained <input type="checkbox"/>
(c)	Contains original signature <input type="checkbox"/>
(d)	Notarized (original) <input type="checkbox"/>
(e)	Original and one copy of each affidavit submitted <input type="checkbox"/>
(f)	SSN on a separate page..... <input type="checkbox"/>

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9. Background investigative reports for company officers, directors and shareholders (including entities) owning 5% or more of applicant.....

10. Background Investigative reports for immediate parent(s) officers, directors and shareholders (including entities) owning 5% or more of parent company's stock.....

11. Background Investigative reports for ultimate parent(s) officers, directors and shareholders (including entities) owning 5% or more of parent company's stock.....

12. Fingerprint cards enclosed for each company officer, director, and shareholder (including entities) owning 5% or more of applicant.....

As to each fingerprint card:

(a) Contains original signature

(b) Florida cards only

(c) All information completed (DOB, citizenship, vital statistics, SSN on a separate page)

13. Fingerprint cards enclosed for each immediate parent(s) officer, director, and shareholder (including entities) owning 5% or more of parent company's stock.....

As to each fingerprint card:

(a) Contains original signature

(b) Florida cards only

(c) All information completed (DOB, citizenship, vital statistics, SSN on a separate page)

14. Fingerprint cards enclosed for each ultimate parent(s) officer, director, and shareholder (including entities) owning 5% or more of parent company's stock.....

As to each fingerprint card:

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- (a) Contains original signature
- (b) Florida cards only
- (c) All information completed (DOB, citizenship,
vital statistics, SSN on a separate page)

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SECTION V - FORMS AND RATES

<u>Item #</u>		<u>Completion Check List</u>
1.	Forms	<input type="checkbox"/>
	(a) 3 copies of each form	<input type="checkbox"/>
	(b) Identified by unique form number	<input type="checkbox"/>
2.	Rates	<input type="checkbox"/>
	(a) 3 copies of each rate schedule and or contract placed with original application	<input type="checkbox"/>
	(b) Rates are neither inadequate, excessive, nor unfairly discriminatory	<input type="checkbox"/>
	(c) Rates are appropriate for class	<input type="checkbox"/>
	(d) Description of rating methodology	<input type="checkbox"/>
	(e) Statement from a qualified actuary that the HMO is actuarially sound	<input type="checkbox"/>

**APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION**

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 _____, that

(Entity Name)

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

RETURN THE COMPLETED CHECK LIST WITH THE APPLICATION PACKAGE.

**APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION**

Pursuant to Chapter 641, Part I, Florida Statutes, application is hereby submitted to form and operate a Health Maintenance Organization.

Proposed name of Health Maintenance Organization:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

FEDERAL IDENTIFICATION NUMBER: _____

PHONE: _____

SOLVENCY CONTACT PERSON: _____

ATTORNEY OR PRINCIPAL FILING THIS APPLICATION:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: _____

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

**APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION**

Signed this _____ day of _____, 20 _____

President or other authorized officer (please print)

Signature

(Corporate Seal)

Second authorized officer (please print)

Signature

State of _____

County of _____

Sworn to and subscribed before me

this _____ day of _____, 20 _____

Notary Public

(Notary Seal)

My Commission Expires

**APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION**

INVOICE

NAME OF HEALTH MAINTENANCE ORGANIZATION: _____

FEIN#: _____

ADDRESS: _____

CITY, STATE & ZIP CODE: _____

PHONE NUMBER: _____

ADDRESS (IF DIFFERENT FROM ARRANGEMENT ADDRESS)

(CITY) (STATE) (ZIP CODE)

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

PLEASE NOTE:

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

For Accounting Use Only

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



OFFICE OF INSURANCE REGULATION

Company Admissions

**APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION
INVOICE**

NAME OF HEALTH MAINTENANCE ORGANIZATION: _____

FEIN#: _____

ADDRESS: _____

CITY, STATE & ZIP CODE: _____

PHONE NUMBER: _____

ADDRESS (IF DIFFERENT FROM ARRANGEMENT ADDRESS)

(CITY)

(STATE)

(ZIP CODE)

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

PLEASE NOTE:

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

For Accounting Use Only

=====

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

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION

REHABILITATION ADMINISTRATIVE EXPENSE FUND
(Pursuant to Section 641.227, F.S.)

NAME OF HEALTH MAINTENANCE ORGANIZATION: _____

FEIN: _____

ADDRESS: _____

CITY, STATE & ZIP CODE: _____

PHONE NUMBER: _____

In reference to the submission of the above-referenced Health Maintenance Organization's Application for Certificate of Authority to do business in Florida, it is necessary for this form to be returned to the address below with proper payment.

PLEASE NOTE:

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

For Accounting Use Only

=====

<u>B/T</u>	<u>TY/CL</u>	<u>F/T</u>	<u>AMOUNT</u>
C	12/00	A	\$10,000

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
Bureau of Life & Health Forms and Rates

SMALL EMPLOYER CARRIER'S APPLICATION TO BECOME A RISK ASSUMING CARRIER OR A REINSURING CARRIER, AS REQUIRED BY SECTION 627.6699(11), FLORIDA STATUTES

CARRIER NAME _____
 ADDRESS (CITYSTZIP) _____
 FEIN: _____ NAIC GROUP CODE: _____ NAIC COMPANY CODE: _____

As required under the provisions of Section 627.6699(11), Florida Statutes, we hereby apply to elect the following status. (Select one block only.)

A. Reinsuring Carrier

A reinsuring carrier, as the term is used in Section 627.6699, Florida Statutes, is a direct writer of small employer health benefit plans and participates in the small employer health reinsurance program created by Section 627.6699 (11). If reinsuring carrier status is elected, nothing further is required except completion of the signature line on page 2 and submission to the Office.

B. Risk Assuming Carrier

If risk-assuming carrier status is elected, attach information showing that the carrier is financially capable of assuming that status pursuant to the criteria in items 1 through 4, below; then complete the signature line at the bottom of the page and send to the Office, Bureau of Life and Health Forms and Rates.

1. The carrier's financial ability to support the assumption of risk of small employer groups. The carrier shall demonstrate that its surplus is adequate to support the fair marketing required by the act and that the planned premium volume after becoming a risk-assuming carrier does not endanger the financial condition of the carrier or endanger the interest of the carrier's policyholder.
2. The carrier's history of rating and underwriting small employers groups. The carrier shall demonstrate that it has successfully engaged in the business of transacting rating and underwriting of small employer groups or is the wholly owned subsidiary of such a company and that its condition and methods of operation in connection with small employer group contracts will not be such as to render its operation hazardous to the public or its policyholders in this state.
3. The carrier's commitment to market fairly to all small employers in the state or its service area, as applicable. The carrier shall include a statement that the applicant has read and will comply with Section 627.6699 (13), Florida Statutes, Standards to Assure Fair Marketing. The Office shall consider the character, responsibility and general fitness of the officers and directors and the past market conduct of the carrier or its representatives.
4. The carrier's ability to assume and manage the risk of enrolling without the protection of the reinsurance program provided by Section 627.6699 (11), Florida Statutes. The Office shall consider the history and financial condition of the company. It should be demonstrated that the financial condition of the carrier is adequate to assume the risk of marketing or their employees' health status to comply with the purpose and intent of the law as stated in Section 627.6699 (2) without the benefit of the special reinsurance program created by Section 627.6699 (11) for reinsuring carriers. If part of the response is that your existing reinsurance program will be depended upon to cover such risks that you may be required to assume, include a copy of the reinsurance treaty with a summary of how it applies to these risks. The requirement of a copy of the reinsurance treaty does not apply to carriers that have a policyholder surplus in excess of \$100,000,000.

C. Not Applicable: The carrier will not issue health benefit plans or products to Florida small employer groups as defined in Section 627.6699, Florida Statutes.

 Signature of Officer _____
 Date

 Name of Officer _____
 Position or Title

PLEASE TYPE OR PRINT DATE, POSITION OR TITLE, AND NAME OF OFFICER

Form OIR-B2-1093 to be submitted as follows:
Office of Insurance Regulation
Bureau of Life & Health Forms and Rates
 Larson Building
 Tallahassee, FL 32399-0328

**FLORIDA DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
MANAGEMENT INFORMATION FORM
COMPLETE LIST OF
OFFICERS, DIRECTORS, AND SHAREHOLDERS (5% OR MORE)**

COMPANY NAME: _____

OFFICERS	TITLES	OWNERSHIP PERCENTAGE
-----------------	---------------	-----------------------------

DIRECTORS:

SHAREHOLDERS:



OFFICE OF INSURANCE REGULATION
Company Admissions

INSTRUCTIONS FOR FURNISHING BACKGROUND INVESTIGATIVE REPORTS

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



Office of Insurance Regulation

Company Admissions

FINGERPRINT CARD AND PAYMENT INSTRUCTIONS

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

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

THE CARD MUST BE SIGNED BY THE APPLICANT.

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

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

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

The following specific instructions should be followed:

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

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

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

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

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

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

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

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

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

FINGERPRINT PAYMENT AND LIVESCAN INSTRUCTIONS

When submitting paper fingerprint cards:

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

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

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

When using the LiveScan Option (Florida residents only):

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

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

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

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

For questions email appcoord@flor.com.

CONFIDENTIAL

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

Applicant's Name: _____

Applicant's Social Security Number: _____

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

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

CONFIDENTIAL



OFFICE OF INSURANCE REGULATION
Company Admissions

Applicant Name _____

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).

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