



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

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**PREPAID HEALTH CLINIC  
APPLICATION FOR CERTIFICATE OF AUTHORITY**

MAIL TO: OFFICE OF INSURANCE REGULATION  
COMPANY ADMISSIONS  
200 EAST GAINES STREET  
TALLAHASSEE, FLORIDA 32399-0332

**Authority**

S. 641.405(1) Pursuant to Chapter 641, Part III, Florida Statutes, application is hereby made to operate a Prepaid Health Clinic.

Proposed name of Prepaid Health Clinic:

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

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

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

How long has the PHC been in operation:  
(Specify beginning date): \_\_\_\_\_

One complete set of application documents must be submitted. Please be specific in your answers and provide supporting documentation for each item. The items are as follows:

## **ORGANIZATIONAL**

- \_\_\_ 1. S. 641.405(2)(f) Enclose a copy of the Health Care Provider Certificate, as issued by the Department of Health and Rehabilitative Services or evidence that application has been made for a Health Care Provider Certificate.
- \_\_\_ 2. S. 641.412(1)(a) A check for \$150 made payable to "Department of Financial Services" covering the filing fee for this application.

### **Authority**

- \_\_\_ 3. S. 641.405(2)(a) A copy of the PHC's basic organizational documents including Articles of Incorporation, Articles of Association, Partnership Agreement(s), Trust Agreement, or other applicable documents and all amendments thereto.
- \_\_\_ 4. S. 641.405(2)(a) If the proposed PHC is already incorporated, a copy of the Certificate of Incorporation as filed with the Secretary of State.
- \_\_\_ 5. S. 641.405(2)(b) A copy of the proposed PHC's Bylaws, Rules or Regulations, or similar form of document.
- \_\_\_ 6. S. 641.405(2)(c) A list of names, addresses, and official capacities of all persons who are to be responsible for the conduct of the PHC's affairs including officers and directors, trustees, partners, and associates.
- \_\_\_ 7. S. 641.406(7) A list of the owners of the PHC, including the number of shares of stock or ownership interest of each person.
- \_\_\_ 8. S. 641.406(7) Complete biographical information, to be submitted on forms provided in this application packet, on all persons controlling 10% or more of the ownership interest of the PHC, and all officers, directors, trustees, partners, or associates of the Prepaid Health Clinic. Submit an original of each Biographical Affidavit.

The requirements for the affiant's social security number (SSN) 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.

\_\_\_\_ 9. S. 641.405(2)(c)

Copies of all contracts, past or current, between the PHC and any person listed in item "6", or with any entity of which any of these persons is an officer, director, partner, trustee, or associate, in which he or any member of his family owns 10% or more of stock or other financial interest including any possible conflicts of interest.

\_\_\_\_ 10. S. 641.406(7)

Documentary evidence that the governing body of the PHC has designated a qualified administrator to manage the PHC's operations. This should include a resume of the administrator.

**Authority**

**CONTRACTUAL**

- \_\_\_\_ 11. S. 641.405(2)(e) Three copies of every contract, rider, endorsement, certificate, application, or other form the PHC proposes to offer to its subscribers. Follow the list of requirements for individual and group contracts enclosed in this application kit, as well as the requirements in the law concerning the definition of basic services and for PHC contracts. Every subscriber contract must be identified by a unique form number located on the lower left corner of each page of the contract.
- \_\_\_\_ 12. S. 641.427 A list of the reasons for which the PHC can terminate a subscriber's contract and the reasons for which the subscriber can terminate his or her contract.
- \_\_\_\_ 13. S. 641.405(2)(e) A table of rates proposed to be charged for each form of subscriber contract.
- \_\_\_\_ 14. S. 641.42(5) A complete description of the procedure established for handling subscriber grievances.

**MARKETING**

- \_\_\_\_ 15. S. 641.405(2)(d) A statement generally describing the clinic and its operations.
- \_\_\_\_ 16. S. 641.441 A copy of all advertising to be used or currently in use. This includes print advertising and scripts for TV or radio advertising.
- \_\_\_\_ 17. S. 641.406(4) A complete explanation of the manner in which the PHC will merchandise subscriber contracts.
- \_\_\_\_ 18. S. 641.405(2)(c) A list of the names and addresses of all sales representatives.
- \_\_\_\_ 19. S. 641.405(2)(e) A statement giving the present (if applicable) projected number of subscribers to be enrolled yearly for the next three years.

## Authority

## FINANCIAL

- \_\_\_\_ 20. S. 641.406(6) Executed copies of the insurance policies covering general liability and medical malpractice insurance for the PHC.
- \_\_\_\_ 21. S. 641.406(6) An executed copy of the PHC's fidelity bond covering employee dishonesty.
- \_\_\_\_ 22. S. 641.406(6) If the PHC has secured catastrophic or back-up insurance coverage (reinsurance for the excess loss coverage), you are required to submit executed copies of the policy or policies.
- \_\_\_\_ 23. S. 641.405(2)(g) A current financial statement, including all assets and liabilities of the PHC, also contingent liabilities, unpaid obligations, and actions or suits pending against or anticipated, prepared on the basis of generally accepted accounting principles.
- \_\_\_\_ 24. S. 641.407 A statement of the proposed initial working capital reserves of the PHC.
- \_\_\_\_ 25. S. 641.405(2)(g) If your group is already operating as a clinic, a profit and loss statement and balance sheet for the past three years.
- \_\_\_\_ 26. S. 641.405(2)(g) If your group has not been operating as a PHC, a pro-forma (projected) operating statement for the first year and a projected balance sheet (statement of financial position) at the end of the first year.
- \_\_\_\_ 27. S. 641.406(3) The method in which the PHC shall comply with the minimum surplus requirement of Section 641.407, Florida Statutes.
- \_\_\_\_ 28. S. 641.405(2)(g) A cash flow analysis of the PHC for the period until the PHC shows three months of profitability. (If the PHC is already profitable, provide one year analysis).
- \_\_\_\_ 29. S. 641.409(1)(a)  
S. 641.409(1)(b)  
S. 641.409(3) The method in which the PHC shall comply with the minimum surplus requirement of Section 641.409, Florida Statutes. All PHCs must make a deposit with the Office of Insurance Regulation in the amount of \$30,000. Also, PHCs must purchase insurance or a surety bond in an amount acceptable to the Office, which shall cover the subscribers in the event of insolvency of the PHC.

**Authority**

- \_\_\_\_ 30. S. 641.406(2) An actuarial analysis of the rates of the PHC, showing that the proposed rates are actuarially sound for the benefits provided, including administrative costs.
- \_\_\_\_ 31. S. 641.405(2)(c) Copies of all relevant business leases.
- \_\_\_\_ 32. S. 641.43 Written contracts identifying each physician or physician group that will be providing service to PHC subscribers. Such contracts must include the hold-harmless clause for subscribers which is required by Section 641.43, Florida Statutes.

This application must be signed by two officers of the PHC and notarized by a notary public.

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

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

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

(SEAL) \_\_\_\_\_

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

**STATE OF FLORIDA  
DEPARTMENT OF FINANCIAL SERVICES  
OFFICE OF INSURANCE REGULATION  
PREPAID HEALTH CLINIC**

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Company Name

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Address

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City, State, Zip

(Fee 641.412, Florida Statutes)

Application	\$100.00	12-43	3092
Filing Fee	\$ 50.00	12-43	2062
Annual Report	\$100.00	12-44	3091
Filing Fee	\$ 50.00	12-44	2062

**Please mail fees to:**

Department of Financial Services  
Bureau of Financial Services  
Post Office Box 6100  
Tallahassee, Florida 32399-6100

**All other correspondence and requests should be sent to:**

Office of Insurance Regulation  
Applications Coordination Section  
200 East Gaines Street  
Tallahassee, Florida 32399-0332

**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
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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