Office of Insurance Regulation
Company Admissions

APPLICATION FOR LICENSE
DISCOUNT MEDICAL PLAN ORGANIZATION (DMPO)

The Office receives applications electronically. Please submit your application at http://www.floir.com/iportal, using the i-Apply link to Online Company Admissions.

This package is designed to assist individuals in preparing the application with all the information required by statute and to facilitate expeditious processing of the application by this Office.

PLEASE NOTE: THE COMPLETED CHECK LIST MUST BE SUBMITTED WITH THE APPLICATION PACKAGE.

The completed application package must be submitted to the Office by utilizing the following link:

http://www.floir.com/iportal
and select iApply – Online Company Admissions

If this package requires submission of forms and/or rates, upon receipt of an email notification of acceptance of the application, the Applicant is directed to return to the Industry Portal http://www.floir.com/iportal and select "Form & Rate Filing Assembly and Submission" to begin the submission of forms and/or rates.

Any questions concerning this application package may be directed to the Application Coordinator at appcoord@floir.com. For iApply only questions, contact the Application Coordinator at iapply@floir.com

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 LICENSE
DISCOUNT MEDICAL PLAN ORGANIZATION (DMPO)

Pursuant to Section 636.Part II, Florida Statutes, in order to do business as a Discount Medical Plan Organization (DMPO), an entity must:

A. Be a corporation, a limited liability company, or a limited partnership, incorporated, organized, formed, or registered under the laws of this state or authorized to transact business in this state in accordance with Chapter 607, Chapter 608, Chapter 617, Chapter 620, or Chapter 865, F.S., and must be licensed by the Office as a discount medical plan organization or be licensed by the Office pursuant to Chapter 624, Part I of Chapter 636, or Chapter 641, F.S.
[s., 636.204(1), F.S.];

B. Be an entity, which in exchange for fees, dues, charges, or other consideration, provides access for plan members to providers of medical services and the right to receive medical services from those providers at a discount. [s.636.202(2), F.S.];

APPLICATION FOR LICENSE
DISCOUNT MEDICAL PLAN ORGANIZATION (DMPO)

INSTRUCTIONS
SECTION I - APPLICATION FEES AND FORM

Section I-1 Application Fee

The application filing fee is $50.00. The initial fee is due and payable at the time of filing the application for licensure. [s.636.204(2)(l) and s.636.204(5),F.S.]

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

Florida Department of Financial Services
Bureau of Financial Services
P.O. Box 6100
Tallahassee, Florida 32314-6100

Copy of Check and Invoice
Place a photocopy of the invoice and the check with your application filing. This procedure will expedite the processing of your application and assure a timely recording of the fees.

Section I-2 Fingerprint Processing Fees

Applicants are required to prepay electronically for the processing of the fingerprint cards required in section IV-4. Please see form OIR-C1-938 for instructions. The fingerprint cards are to be submitted with the application filing.

Place a copy of your on-line payment confirmation along with the fingerprint cards in the management section (IV-4).

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

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

Section I-3 Application for License (Official Form included with this package)

This form must be sworn to by an officer or authorized representative of the applicant.

SECTION II-LEGAL

Section II-1 Articles of Incorporation

Include in this section the applicant's Articles of Incorporation or other organizing documents, including all amendments. The required filings must be recently certified by the official public records custodian in the applicant's state of domicile. The certification letter must be an original. [s.636.204(2)(a), F.S.]

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

Provide a Certificate of Status document issued by the Florida Secretary of State which certifies that the applicant is authorized in this State and that all state taxes and fees have been paid. This certificate must be obtained from the Florida Secretary of State's office and be an original. [s.636.204(1), F.S.]

If you have any questions concerning filing with the Secretary of State, please contact the Division of Corporations at (850) 245-6051 or see http://www.sunbiz.org/.

Important note: The Secretary of State will issue a charter to a discount medical plan organization before the Office completes its processing of an application for a license. This charter authorizes the company to engage in any type of business except insurance or discount medical plans, or other regulated business.

Your company MAY NOT engage in the business of a medical discount plan in Florida until it has been issued a license by the Commissioner of the Office.

Section II-3 By-Laws, Constitution, or Rules and Regulations

Include a copy of the applicant's By-Laws, Constitution, and/or Rules and Regulations in this section. The bylaws must be sealed, signed and recently dated by the Secretary of the company. No signatures other than the Secretary's will be accepted.
[s. 636.204(2)(b), F.S.]

Section II-4 Certificate of Compliance (Foreign Applicants Only)

If applicable, provide a Certificate of Compliance issued by the public official having supervision in applicant's state of domicile showing that the company is organized and authorized to issue contracts and the kinds of contracts it is authorized to transact. The certificate should be an original under seal by the organization's state of domicile. If not applicable, please state this in the application.

Section II-5 Service of Process Form

[s.636.234, 624.422 and 624.423 F.S.]

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

SECTION III - FINANCIAL AND RELATED INFORMATION

Section III-1 Marketing and Growth

Submit a description of the proposed method of marketing, including the target groups, types of discounts to be offered, and advertising media to be used.
[s. 636.204(2)(j), F.S.]

Section III-2 Advertising

Provide a description of the procedures in place for the DMPO to approve advertising, prior to use, pursuant to Section 636.228, Florida Statutes.

Please note that although advertisements are not required to be filed for prior approval, the company is required to maintain compliance with Rule 69O-203.204, which provides standards for advertisements and Rule 69O-203.205, which provides advertisement enforcement procedures.

Section III-3 Website

Prior to licensure by the Office, each DMPO must establish an Internet website that conforms to the requirements of Section 636.226, Florida Statutes. [s. 636.204(4)] This website should also comply with the disclosures required in s. 636.212, F.S. and should not include any prohibitions listed in s. 636.210, F.S.

Provide the address of the website that complies with these statutes.

Section III-4 Financial

A. Submit a copy of the applicant's most recent financial statements audited by an independent certified public accountant [s.636.204,(2)(i), F.S.], and provide the date of the company's fiscal year end.

B. Each DMPO must at all times maintain a net worth of at least $150,000. [s.636.220(1), F.S.]

   The OFFICE may not issue a license unless the DMPO has a net worth of at least $150,000.
   [s.636.220(2), F.S.]

C. Documentation that the applicant has complied with the surety bond or security deposit requirements [636.236(1), Florida Statutes]. For security deposits, contact the Bureau of Collateral Management at (850) 413-3167.

(1) Each DMPO must maintain in force (unless deposit is placed in lieu of the bond) a surety bond in its own name in an amount not less than $35,000 to be used at the discretion of the Office to protect the financial interest of members who may be adversely affected by the insolvency of a DMPO. The bond must be issued by an insurance company that is licensed to do business in this state.

(2) In lieu of #1 above, each DMPO shall deposit with the Bureau of Collateral Management cash or securities of the type eligible under Section 625.52, Florida Statues, which shall have at all times a market value of $35,000.

(3) If for any reason the market value of assets and securities of DMPO held on deposit in this state falls below the amount required, the organization shall promptly deposit other or additional assets or securities eligible for deposit sufficient to cure the deficiency.

Section III-5 Contractual

A. A copy of the form of all contracts made or to be made between the applicant and any providers or provider networks regarding the provision of medical services to members. [s. 636.204(2)(f), F.S.]

B. A copy of the form of any contract made or to be made between the applicant and 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 services to members. [s. 636.204(2)(h), F. S.]

C. A copy of the form of any contract made or arrangement to be made between the applicant and any person listed in the Management Section (Section IV) of this application as individuals who are responsible for conducting the applicant's affairs, including but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the officers, contracted management company personnel, and any person or entity owning or having the right to acquire 10% or more voting securities of the applicant. [s. 636.204(2)(c) and (g), F.S.]

Section III-6 A statement generally describing the applicant, its facilities and personnel, and the medical services to be offered. [s. 636.204(2)(e), F.S.]

Section III-7 A description of the subscriber complaint procedures to be established and maintained. [s. 636.204,(2)(k), F.S.]

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 [s.636.204(2)(c) F.S.]

A. List the names, addresses and official positions of each officer, director and any person having direct or indirect control of the organization, including but not limited to contracted management company personnel (form included in this package).

B. List the names of each stockholder owning ten percent or more of voting securities of the applicant or any person having the right to acquire ten percent or more 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 DMPO, 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 [s.636.204(2)(d),F.S.]

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

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

The requirement for the affiant's social security number as part of the Biographical Affidavit is mandatory. However, pursuant to sections 119.071(5), Florida Statutes, social security numbers collected by an agency are confidential and exempt from section 119.07(1), Florida Statutes, and section 24(a), Art. I of the State Constitution and must be segregated on a separate page. Therefore,

instead of including the SSN on page 6 of the NAIC form, please include the affiant's name and social security number on a separate page
and attach it to the Biographical Affidavit. Also please stamp CONFIDENTIAL at the top and bottom of the separate page.

Section 119.071(5), Florida Statutes, gives authority for an agency to collect social security numbers if imperative for the performance of that agency's duties and responsibilities as prescribed by law. Limited collection of social security numbers is imperative for the Office. The duties of the Office in background investigation are extensive in order to insure that the owners, management, officers, and directors of any insurer are competent and trustworthy, possess financial standing and business experience, and have not been found guilty of, or not pleaded guilty or nolo contendere to, any felony or crime punishable by imprisonment of one year.

Section IV-3 Investigative Background Reports [636.204(2)(d) F.S.]

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 prior to or contemporaneously with the application filing. Please refer to form OIR-C1-905 for instructions.

Section IV-4 Fingerprint Cards

Fingerprint cards must be completed for each person listed in Section IV-1 (except for those companies in the organizational structure between the immediate parent and the ultimate parent). [s.636.204(2)(d),F.S.]

The fingerprint cards along with the fees are due at the time the application is filed. **No cards other than those furnished by the Office will be accepted.** These cards must be completed at a law enforcement or similar type agency and returned to this Office for processing. Please refer to form OIR-C1-938 for instructions.

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.

SECTION V - FORMS AND RATES

NOTE: THE COMPANY CAN SUBMIT ITS FORMS AND RATES ONLY AFTER RECEIVING A NOTICE FROM THIS OFFICE THAT THIS APPLICATION HAS BEEN ACCEPTED. FORMS AND RATES SHOULD BE SUBMITTED TOGETHER IN THE SAME FILING. THE COMPANY IS PROHIBITED FROM WRITING BUSINESS USING UNAPPROVED FORMS OR RATES.

Section V-1 Forms

(See Rule 69O-203.203, for Discount Medical Plan Standards)
All form filings shall be submitted to the Office electronically to https://iportal.fldfs.com.

Section V-2 Rates

(See Rule 69O-203.204, for Discount Medical Plan Rate Standards)
All rate filings shall be submitted to the Office electronically to https://iportal.fldfs.com.

APPLICATION FOR LICENSE
DISCOUNT MEDICAL PLAN ORGANIZATION (DMPO)

CHECK LIST
SECTION I - APPLICATION FEES AND FORM

Company Name: _____

Item #		Completion Check List
1.	Insurer application fees paid	☐
	(a) Copy of invoice included (Official Form)	☐
	(b) Copy of check	☐
	(c) Placed in Section I	☐
	(d) Originals mailed to Bureau of Financial Services	☐
2.	Fingerprint fee paid electronically	☐
	a. Copy of on-line payment confirmation	☐
	or, if applicable	
	b. Copy of form OIR-C1-903 (invoice) included	☐
	c. Copy of check included	☐
	d. Originals mailed to Bureau of Financial Services	☐
3.	Application for License (Official Form)	☐
	(a) All blanks completed	☐
	(b) If applicable, sealed by corporation	☐
	(c) Signed by President or other authorized officer (original signature)	☐

APPLICATION FOR LICENSE
DISCOUNT MEDICAL PLAN ORGANIZATION (DMPO)

SECTION II - LEGAL

Company Name: _____

Item #			Completion Check List
1.	Articles of Incorporation or other organizing documents and all amendments attached with an original certification by the State of Domicile		☐
2.	Certificate of Status from Florida Secretary of State (original document)		☐
	(a)	Good standing indicated	☐
	(b)	Sealed by state	☐
	(c)	Signed by proper public official	☐
	(d)	Original	☐
3.	Corporate By-Laws, Rules and Regulations, and/or Constitution		☐
	(a)	Signed and dated by applicant's secretary	☐
	(b)	If applicable, sealed by corporation	☐

APPLICATION FOR LICENSE
DISCOUNT MEDICAL PLAN ORGANIZATION (DMPO)

Section II - Legal
Required Filing and Check List

Item #			Completion Check List
4.	Certificate of Compliance from State of domicile		☐
	(a)	Original Certification from State of domicile	☐
	(b)	Form indicates the kinds of contracts the company is authorized to transact	☐
	(c)	Not applicable	☐
5.	Service of Process Form.....		☐

APPLICATION FOR LICENSE
DISCOUNT MEDICAL PLAN ORGANIZATION (DMPO)

SECTION III - FINANCIAL AND RELATED INFORMATION

Company Name: _____

Item #		Completion Check List
1.	Marketing and growth	☐
	(a) Description of marketing methods.....	☐
2.	Advertising.....	☐
	(a) Include a description of advertising procedures.....	☐
3.	Provide website address.....	☐
4.	Financial	☐
	A. Current audited financial statements & fiscal year end date ...	☐
	B. Compliance with minimum surplus requirement.....	☐
	C. Original document evidencing compliance with surety bond requirement or security deposit requirement as explained in S.III-4C 1&2.....	☐
5.	Contractual Documents	☐
	(a) Provider contract form	☐
	(b) Other forms of contracts per s.636.204(2)(h), F.S.....	☐
	(c) Other forms of contracts per s.636.204(2)(c) and (g), F.S.	☐
6.	Statement describing facilities, personnel and medical services	☐
7.	Description of subscriber complaint procedures……	☐

APPLICATION FOR LICENSE
DISCOUNT MEDICAL PLAN ORGANIZATION (DMPO)

SECTION IV – MANAGEMENT

Note: This portion of the checklist is detailed in order to assist the applicant in ensuring all items are completed, and checklist item numbers will not correlate with item numbers in the Instructions.

Item #		Completion Check List
1.	Listing of all officers, directors, and shareholders (including entities owning 10% or more of applicant (Form OIR-C1-1298).	☐
2.	Listing of all immediate parent(s) officers, directors and shareholders (including entities) owning 10% or more of parent company's stock (Form OIR-C1-1298)	☐
3.	Listing of all intermediary parent(s) (between immediate parent(s) and ultimate parent(s)), officers and shareholders (including entities) owning 10% or more of parent company's stock (Form OIR-C1-1298). Note, do not complete Form OIR-C1-1423, (Biographical Affidavits), or order investigative reports or fingerprint cards	☐
4.	Listing of all ultimate parent(s) officers, directors and shareholders (including entities) owning 10% or more of parent company's stock (Form OIR-C1-1298)	☐
5.	Organizational Chart including all entities within the ultimate parent company structure	☐
6.	Biographical Affidavits for company officers, directors and shareholders (including entities) owning 10% or more of applicant (Form OIR-C1-1423)	☐
	As to each biographical:	
	(a) All blanks completed.....	☐
	(b) "Yes" answers explained	☐
	(c) Contains original signature	☐

Section IV-Management
Required Filing and Check List

Item #		Completion Check List
	(d) Notarized (original)	☐
	(e) SSN on a separate page…..……	☐
7.	Biographical Affidavits for immediate parent(s) officers, directors and shareholders (including entities) owning 10% or more of parent Company's stock (Form OIR-C1-1423)	☐
	As to each biographical:	
	(a) All blanks completed	☐
	(b) "Yes" answers explained	☐
	(c) Contains original signature	☐
	(d) Notarized (original)	☐
	(e) SSN on a separate page	☐
8.	Biographical Affidavits for ultimate parent(s) officers, directors and Shareholders (including entities) owning 10% or more of parent company's Stock (Form OIR-C1-1423)	
	As to each biographical:	
	(a) All blanks completed	☐
	(b) "Yes" answers explained	☐

Section IV-Management
Required Filing and Check List

Item #		Completion Check List
	(c) Contains original signature	☐
	(d) Notarized (original)	☐
	(e) SSN on a separate page…..……	☐
9.	Background investigative reports for company officers, directors and shareholders (including entities) owning 10% or more of applicant.....	☐
10.	Background Investigative reports for immediate parent(s) officers, directors and shareholders (including entities) owning 10% or more of parent company's stock	☐
11.	Background Investigative reports for ultimate parent(s) officers, directors and shareholders (including entities) owning 10% or more of parent company's stock	☐

Note: If fingerprints are digitally scanned, Items 12, 13 and 14 are not applicable.

12.	Fingerprint cards enclosed for each company officer, director, and shareholder (including entities) owning 10% 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 10% 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 10% 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) ..... ☐

APPLICATION FOR LICENSE
DISCOUNT MEDICAL PLAN ORGANIZATION (DMPO)

CHECKLIST VERIFICATION

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

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

Dated _____ _____
(Give full and exact name of Applicant)

_____
Signature of President, Secretary, or Treasurer

_____ _____
Printed Name Printed Title

APPLICATION FOR LICENSE
DISCOUNT MEDICAL PLAN ORGANIZATION (DMPO)

Pursuant to Chapter 636, Part II Florida Statutes, application is hereby submitted to form and operate a Discount Medical Plan Organization.

In order to qualify as a Discount Medical Plan Organization (DMPO), an entity must:

A. Be a corporation, a limited liability company, or a limited partnership, incorporated, organized, formed, or registered under the laws of this state or authorized to transact business in this state in accordance with Chapter 607, Chapter 608, Chapter 617, Chapter 620, or Chapter 865, F.S., and must be licensed by the Office as a discount medical plan organization or be licensed by the Office pursuant to Chapter 624, Part I of Chapter 636, or Chapter 641, F.S. [s., 636.204(1), F.S.];

B. Be an entity which, in exchange for fees, dues, charges, or other consideration, provides access for plan members to providers of medical services and the right to receive medical services from those providers at a discount. [s.636.202(2), F.S.];

Proposed name of Discount Medical Plan Organization:

NAME: _____

ADDRESS: _____

CITY: _____STATE:_____ ZIP CODE: _____

FEDERAL IDENTIFICATION NUMBER: _____

PHONE:_____

CONTACT PERSON: _____
E-MAIL:_____FAX:_____

ATTORNEY OR PRINCIPAL FILING THIS APPLICATION:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ZIP CODE: _____

PHONE:_____E-MAIL_____FAX:_____

APPLICATION FOR LICENSE
DISCOUNT MEDICAL PLAN ORGANIZATION (DMPO)

This company, through its duly authorized officers, hereby applies for a license authorizing and empowering it to operate as a discount medical plan 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.

Signed this _____ day of _____, 20___

_____
President or other authorized officer
(Please print)

_____
Signature (Corporate Seal)

State of _____

County of _____

Sworn to and subscribed before me this ____ day of _____20__

_____
Notary Public

(Notary Seal)

_____
My Commission Expires

APPLICATION FOR LICENSE
DISCOUNT MEDICAL PLAN ORGANIZATION (DMPO)

INVOICE
PAYMENT OF APPLICATION FEE

NAME OF COMPANY: _____

FEIN #: _____

ADDRESS: _____

CITY, STATE & ZIP CODE: _____

PHONE NUMBER: _____

ADDRESS (IF DIFFERENT FROM STREET ADDRESS)

_____

_____
(CITY) (STATE) (ZIP CODE)

E-MAIL ADDRESS:_____FAX_____

In reference to the recent submission by the above-referenced discount medical plan organization regarding its application to do business in Florida, it is necessary that you return this form with the proper payment as listed below.

PLEASE NOTE:

1. Send the original check for $50 made payable to the Florida Department of Financial Services, and mail the check and invoice to the Department of Financial Services, Bureau of Financial Services, P.O. Box 6100, Tallahassee, Florida 32314-6100.
2. Send a copy of the check and a copy of the invoice along with the completed application package to the Office of Insurance Regulation, Applications Coordination Section, 200 East Gaines Street, Larson Building, Tallahassee, Florida 32399-0332.

If you have any questions, please contact Applications Coordination at (850) 413-2575.

	B/T	TY/CL	F/T	AMOUNT
Filing Fee	C	1249F	F	$ 50.00

SERVICE OF PROCESS CONSENT & AGREEMENT

(Please type or print all information clearly)

☐ *Original Designation* ☐ *Insurer Name Change* ☐ *Merger / Acquisition* ☐ *Update Delivery Information*

*Insurer or Company Name:*_____
Previous Name (If applicable): _____
Home Office Address: _____
City, State, Zip _____

_____ _____ _____
FEI # *FL Company Code* *Telephone #*

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

Said entity does hereby agree and consent that actions may be commenced against it in any court having jurisdiction in any county in the State of Florida, in which a cause of action may arise, or in which the plaintiff may reside, by the service of process upon the Chief Financial Officer of the State of Florida. Said entity also hereby stipulates and agrees that any and all process so served shall be taken and held in all Courts to be as valid and binding upon this insurer or other entity as if personal service had been made upon the President or Secretary, or any other duly authorized and accredited officer thereof.

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

Designated Person to receive process: _____ ***E-Mail Address:***_____
Phone*#:*_____ ***Fax****#*_____

Mailing Address: _____ ***Street Address****:*_____
_____ _____
_____ _____

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

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

_____
President or CEO's Signature

_____
President or CEO's Name(Typed or Printed)

SEAL

_____
Secretary's Signature

_____
Secretary's Name (Typed or Printed)

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

OIR-C1-144
Rev 06/2004

Service of Process Section
200 East Gaines Street • PO Box 6200 • Tallahassee, FL 32314-6200 •(850) 413-4200 • Fax (850) 922-2544

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/documents/industry_ucaa_third_party.pdf "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@floir.com in Microsoft Word format, with appropriate reference to the applicant in the subject of each transmittal e-mail. Reports should be submitted prior to or contemporaneously with the submission of each application filing, with the exception of acquisition filings.

6. Applicants must include evidence indicating that background reports have been ordered, including proof of payment, as a component in the online submission via iApply.

7. Any questions regarding this process may be directed to the Office at appcoord@floir.com

Office of Insurance Regulation
Company Admissions

FINGERPRINT PAYMENT AND SUBMISSION PROCEDURE

LiveScan (available to Florida Residents):

Applicants must pay online for processing of electronic fingerprints and make appointment for electronic fingerprinting. To begin the process, access MorphoTrustUSA

- Select English or Spanish to continue
- Enter First Name and Last Name
- Select "Continue"
- Enter Zip Code to determine closest fingerprint location or Choose "Region" and select "Go"
- Schedule Appointment
- Enter Applicant Information and select "Send Information"
- Verify and Select "Go"
- Select "Method of Payment" and "Send Payment Information"
- Select "Continue to US Bank E-Pay"
- Retain copy of payment confirmation

Paper Card* (available to Florida Residents and Non-Residents):

Applicants must pay online for processing fingerprint cards. To begin the process, access MorphoTrustUSA

- Select English or Spanish to continue
- Enter First Name and Last Name and select "Go"
- Select "Non-Resident Card Submission" (Non-Residents and Florida Residents not utilizing LiveScan)
- Select "No Cards"
- Enter Applicant Information and select "Send Information". If Applicant does not have a Social Security Number, enter "123-12-1234" in the required SSN field
- Verify and Select "Go"
- Select "Method of Payment" and "Send Payment Information"
- Select "Continue to US Bank E-Pay"
- Retain copy of payment confirmation
- Mail completed cards with a cover letter to: Florida Office of Insurance Regulation
  Company Admissions
  200 East Gaines Street
  Tallahassee, Florida 32399-0332

Applicants may contact MorphoTrust USA's toll free registration center at 1-800-528-1358 regarding payment and/or appointment issues.

*Applicants must use fingerprint cards provided by the Office. Applicants must provide **two** completed cards per person. Blank fingerprint cards may be requested by emailing appcoord@floir.com or calling 850-413-2575.

Payment confirmations will be a required component in the electronic application submitted via iApply.

Questions may be emailed to appcoord@floir.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

Applicant Company 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. Affiant's Full Name (Initials Not Acceptable): First:_____Middle:_____Last:_____

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

   Yes ☐ No ☐

   b. Are you a citizen of any other country?

   Yes ☐ No ☐

   If yes, what country? _____

3. Affiant's occupation or profession:_____

4. Affiant's business address:_____

   Business telephone: _____ Business Email: _____

5. Education and training:

College/University	City/State	Dates Attended (MM/YY)	Degree Obtained

Graduate Studies	College/University	City/State	Dates Attended (MM/YY)	Degree Obtained

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

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

Applicant Company Name : _____ NAIC No. _____
FEIN: _____

6. List of memberships in professional societies and associations:

Name of Society/Association	Contact Name	Address of Society/Association	Telephone Number of Society/Association

7. Present or proposed position with the Applicant Company: _____

_____

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

Beginning/Ending
Dates (MM/YY):_____ - _____ Employer's Name: _____

Address:_____ City: _____ State/Province: _____

Country:_____ Postal Code:_____ Phone: _____ Offices/Positions Held: _____

Type of Business: _____ Supervisor/Contact: _____

Beginning/Ending
Dates (MM/YY):_____ - _____ Employer's Name: _____

Address:_____ City:_____ State/Province: _____

Country:_____ Postal Code:_____ Phone: _____ Offices/Positions Held:_____

Type of Business: _____ Supervisor/Contact: _____

Beginning/Ending
Dates (MM/YY):_____ - _____ Employer's Name: _____

Address:_____ City: _____State/Province: _____

Country:_____ Postal Code:_____ Phone: _____ Offices/Positions Held:_____

Type of Business: _____ Supervisor/Contact: _____

Beginning/Ending
Dates (MM/YY):_____ - _____ Employer's Name: _____

Address:_____ City: _____State/Province: _____

Country:_____ Postal Code:_____ Phone: _____ Offices/Positions Held:_____

Type of Business: _____ Supervisor/Contact: _____

Applicant Company Name : _____ NAIC No. _____
FEIN: _____

9. a. Have you ever been in a position which required a fidelity bond?

Yes ☐ No ☐

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?

Yes ☐ No ☐

If yes, give details:_____
_____

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

_____
_____

Organization/Issuer of License: _____ Address: _____

City: _____ State/Province: _____ Country: _____ Postal Code: _____

License Type:_____ License #:_____ Date Issued (MM/YY):_____

Date Expired (MM/YY): _____ Reason for Termination: _____

Non-Insurance Regulatory Phone Number (if known): _____

Organization/Issuer of License: _____ Address: _____

City: _____ State/Province: _____ Country: _____ Postal Code:_____

License Type:_____License #: _____ Date Issued (MM/YY):_____

Date Expired (MM/YY): _____ Reason for Termination: _____

Non-Insurance Regulatory Phone Number (if known): _____

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

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

Yes ☐ No ☐

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?

Yes ☐ No ☐

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?

Yes ☐ No ☐

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?

Yes ☐ No ☐

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?

Yes ☐ No ☐

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?

Yes ☐ No ☐

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?

Yes ☐ No ☐

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?

Yes ☐ No ☐

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?

Yes ☐ No ☐

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?

Yes ☐ No ☐

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

_____

_____

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

holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.

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

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

Yes ☐ No ☐

If 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.

14. Have you ever been adjudged a bankrupt?

Yes ☐ No ☐

If yes, provide details: _____

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity?

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

Yes ☐ No ☐

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)?

Yes ☐ No ☐

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?

Yes ☐ No ☐

Applicant Company Name : _____ NAIC No. _____
FEIN: _____

If the answer to any of the above is 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. _____

_____

_____

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

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

_____
(Signature of Affiant)

State of: _____ County of: _____

The foregoing instrument was acknowledged before me this ____day of _____, 20____ by _____,

and:

☐ who is personally known to me, or

☐ who produced the following identification: _____.

[SEAL]

_____
Notary Public

_____
Printed Notary Name

_____
My Commission Expires

Applicant Company Name : _____ NAIC No. _____
FEIN: _____

BIOGRAPHICAL AFFIDAVIT
Supplemental Personal Information

(Print or Type)

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

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

_____

_____

_____

1. Affiant's Full Name (Initials Not Acceptable): First:_____ Middle:_____ Last:_____
   IF ANSWER IS "NONE," SO STATE.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?

   Yes ☐ No ☐

   If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

Beginning/Ending Date(s) Used (MM/YY)	Name(s) Specify: First, Middle or Last Name	Reason (If none, indicate such)

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

3. Affiant's Social Security Number: _____

4. Government Identification Number if not a U.S. Citizen:_____

5. Foreign Student ID# (if applicable) :_____

6. Date of Birth: (MM/DD/YY) : _____Place of Birth, City: _____
   State/Province:_____Country: _____

7. Name of Affiant's Spouse (if applicable) : _____

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

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

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

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

_____
(Signature of Affiant)

State of: _____ County of: _____

The foregoing instrument was acknowledged before me this _____ day of _____, 20_____ by _____, and:

☐ who is personally known to me, or

☐ who produced the following identification: _____

[SEAL]

_____
Notary Public

_____
Printed Notary Name

_____
My Commission Expires

Applicant Company Name : _____ NAIC No. _____
FEIN: _____

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

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of _____ **[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 _____ **[company's designated person, position, or department, address and phone]**.

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

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

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

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

_____
(Printed Full Name and Residence Address)

_____ _____
(Signature) (Date)

State of: _____ County of: _____

The foregoing instrument was acknowledged before me this _____ day of _____, 20_____ by _____, and:

☐ who is personally known to me, or

☐ who produced the following identification: _____

[SEAL]

_____
Notary Public

_____
Printed Notary Name

_____
My Commission Expires

Applicant Company Name : _____ NAIC No. _____
FEIN: _____

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

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of _____**[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 _____ **[company's designated person, position, or department, address and phone]**.

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

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

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

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

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

_____
(Printed Full Name and Residence Address)

_____ _____
(Signature) (Date)

State of:_____ County of: _____

The foregoing instrument was acknowledged before me this _____day of_____, 20_____ by _____, and:

☐ who is personally known to me, or

☐ who produced the following identification: _____

[SEAL]

_____
Notary Public

_____
Printed Notary Name

_____
My Commission Expires

Applicant Company Name : _____ NAIC No. _____
FEIN: _____

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS
(*California)*

This Disclosure and Authorization is provided to you in connection with a pending application of _____ **[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 _____ **[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 _____ **[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

OFFICE OF INSURANCE REGULATION
Company Admissions

MANAGEMENT INFORMATION FORM
COMPLETE LIST OF OFFICERS, DIRECTORS, AND SHAREHOLDERS (10% OR MORE)

COMPANY NAME:_____

OFFICERS:	**TITLES:**	**OWNERSHIP PERCENTAGE:**

DIRECTORS:

SHAREHOLDERS: