



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

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**APPLICATION FOR ACQUISITION OF CONTROLLING STOCK FOR  
SPECIALTY INSURERS**

**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](mailto:appcoord@floir.com). For iApply only questions, contact the Application Coordinator at [iapply@floir.com](mailto: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.**



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

**STATEMENT OF  
ACQUISITION MERGER OR CONSOLIDATION OF  
A SPECIALTY INSURER  
PURSUANT TO  
FLORIDA STATUTES 628.4615**

1. Acquiring Company:

\_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City, State, Zip)

\_\_\_\_\_  
(Telephone Number)

\_\_\_\_\_  
(Federal Identification Number)

\_\_\_\_\_  
(Contact Person)

2. Specialty Insurer Affected: Certificate of Authority or License Number

\_\_\_\_\_  
(Type of Certificate of Authority)

\_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City, State, Zip)

\_\_\_\_\_  
(Telephone Number)

\_\_\_\_\_  
(Federal Identification Number)

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3. This filing is for (check those applicable):

- |  |                          |
|--|--------------------------|
| a) Acquisition of Controlling Stock (Corporation)  | <input type="checkbox"/> |
| b) Acquisition of ownership interest (Partnership) | <input type="checkbox"/> |
| c) Acquisition of parent company                   | <input type="checkbox"/> |
| d) Merger or Consolidation                         | <input type="checkbox"/> |

4. Check one or both of the following:

- a) This filing affects a Specialty Insurer licensed with the Office of Insurance Regulation pursuant to Chapter, Florida Statutes.
- b) This filing affects a company which controls a Specialty Insurer licensed with the Office of Insurance Regulation pursuant to Chapter, Florida Statutes.

5. The transaction for which this form is filed is scheduled to Occur \_\_\_\_\_ or, if it is a post filing, occurred \_\_\_\_\_

6. In summary, the transaction is as follows: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. A statement of Acquisition, Consolidation or Merger was submitted to the Office of Insurance Regulation on \_\_\_\_\_ (date submitted).

8. This statement was sent by registered mail on \_\_\_\_\_ (date sent) to the Specialty Insurer and any controlling company, if applicable. Please note any additional information required by the Office of Insurance Regulation pursuant to Section 628.4615(4), Florida Statutes, must also be sent by registered mail to the Specialty Insurer and to the controlling company of the Specialty Insurer.

Provide documentation to support this information was received.

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9. Have there been any material changes in the facts set forth in the Statement of Acquisition, Consolidation or Merger since it was filed by the Office of Insurance Regulation?

\_\_\_Yes \_\_\_No

If yes, include amendments, which set forth the changes. If yes, when was the notice of these changes sent to the affected parties (listed in #8) by registered mail \_\_\_\_\_(date sent)?

10. a) Does the acquiring person or persons plan to:

i) Liquidate the Specialty Insurer? \_\_\_\_\_Yes \_\_\_No

ii) Sell its assets? \_\_\_ Yes \_\_\_ No

iii) Merge or consolidate with any other person? \_\_\_\_\_ Yes\_\_\_\_\_ No

iv) Make any major change in its business or corporate structure or management? \_\_\_ Yes \_\_\_ No

(If the acquirer does intend to do one or more of the above, such plan must demonstrate that it is fair and free of prejudice to the insureds of the Specialty Insurer and to the public. The burden of proof is on the acquiring entity.)

- b) Does the acquiring person plan to:

i) Liquidate the parent of the Specialty Insurer? \_\_\_\_\_Yes \_\_\_ No

ii) Sell the assets of the parent of the Specialty Insurer?  
\_\_\_\_\_ Yes \_\_\_No

iii) Merge the parent or consolidate it with any other person?  
\_\_\_\_\_ Yes \_\_\_ No

iv) Make any major change in the parent's business or corporation structure or management? \_\_\_ Yes \_\_\_\_\_No

(If the acquirer does intend to do one or more of the above, such plan must demonstrate that it is fair and free of prejudice to the insureds of the Specialty Insurer and to the public. The burden of proof is on the acquiring entity.)

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11. Upon completion of the acquisition, will the Specialty Insurer be able to satisfy the requirement for the issuance of a license or certificate to write the line of insurance for which it is presently licensed or certified? \_\_\_\_\_ Yes \_\_\_\_\_ No

If "NO", explain.

12. If the acquisition has already taken place, has the acquirer agreed not to make any material changes in the management or operation of the Specialty Insurer or its controlling company while this application is being considered?  
\_\_\_\_ Yes\_\_\_\_ No

a) Has the acquirer agreed not to obligate 5% or more of its net worth?  
\_\_\_\_ Yes \_\_\_\_ No

b) Has the acquirer agreed not to make any managerial changes?  
\_\_\_\_ Yes \_\_\_\_ No

13. For HMOs only:

a) If for-profit, a statement setting forth method of compliance with Florida Statute 628.451.

b) If non-profit, a statement setting forth method of compliance with Florida Statute 628.471.

14. Identify the source and amount of the funds or other consideration used, or  
15. to be used, in making the acquisition.

**EXHIBITS**

1. All written agreements between parties.
2. Summary of any verbal agreements between parties including:
  - a) Any transfer of securities?
  - b) Any option arrangements?
  - c) Any puts or calls?
  - d) Any proxies given or received?

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3. Description of the transaction including:
  - a) Controlling interest;
  - b) Terms of the acquisition;
  - c) Number and percentage of shares to be acquired;
  - d) Any transfer of securities, any option arrangements, any calls, any proxies given or received.
4. Financial statements of the acquiring company which clearly indicate the acquiring company can fulfill its financial responsibilities.
5. Evidence that all required reserves are in place.
6. Copies of all new or revised escrows, contracts or agreements which demonstrate compliance with all applicable statutory provisions by the acquiring company.
7. Evidence that the status of revised and existing escrows, contracts or agreements with the consumer are, and will be, satisfactory.
8. If needed, copies of pro-forma financial statements which clearly demonstrate the effect of the acquisition after completion of the transaction.
9. A statement outlining material changes in the operation or business operations of the affected company or a statement citing no adverse material change in operations.
10. Certified copies of the appropriate organizational documents of the acquiring company, i.e., Articles of Incorporation, Bylaws, Partnership Agreements, Certificate of Good Standing, etc. and 1 facsimile copy of each.
11. Evidence that all requirements have been met with respect to:
  - a) Bonding
  - b) Deposits
  - c) Reserves
  - d) Solvency
  - e) Insurance
12. Status of existing debts or obligations including all claims of the Specialty Insurer.

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13. An organizational chart indicating the corporate structure of the acquiring entity and the seller which reflects all affiliate entities prior to and subsequent to the acquisition for each.
14. The following background information must be provided to the Office of Insurance Regulation for each natural person who possesses, directly or indirectly, the power to direct or cause the direction of the management policies of the applicant, whether through the ownership of voting securities, title or position, by contract or otherwise; including all partners, and if a corporation, all stockholders and directors, and the President, Chief Executive Officer, all Vice-Presidents, Secretary, Treasurer and Chief Financial Officer.
  - a) Biographical Affidavits
  - b) Fingerprint Cards
  - c) Investigative Reports

The requirements for the affiant's social security number as part of the Biographical Affidavit is mandatory. However, pursuant to sections 119.071(5), Florida Statutes, social security numbers collected by an agency are confidential and exempt from section 119.07(1), Florida Statutes, and section 24(a), Art. I of the State Constitution and must be segregated on a separate page. Therefore, instead of including the SSN on page 6 of the Biographical Affidavit, please include the affiant's name and social security on a separate page and attach it to the Biographical Affidavit. Also please stamp CONFIDENTIAL at the top and bottom of the separate page.

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

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

A copy of your on-line payment confirmation along with the fingerprint cards must be provided with your application.

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

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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.**

Background reports must be submitted by the selected background investigator vendor directly to the Office prior to or contemporaneously with the submission of the application filing. Please refer to form OIR-C1-905 for instructions.

15. "Waiver of Public Hearing and Request for Approval," Form.
16. If an HMO, file documents supporting compliance with Florida Statutes 628.451 or 628.471, as applicable.
17. Other (identify and explain):

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**The Following Attestation Form Shall Be Used:**

I, the undersigned, do hereby affirm that all the responses, information, exhibits and documentary evidence submitted with and in support of this application are true and correct.

(Corporate Seal)

\_\_\_\_\_  
(Typed Name and Title)

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

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

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

Sworn to and subscribed before me

this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

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

(Seal)

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

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**WAIVER OF PUBLIC HEARING AND REQUEST FOR APPROVAL**

We, the undersigned, on behalf of \_\_\_\_\_  
hereby waive our right to a public hearing on the proposed acquisition of  
\_\_\_\_\_ by \_\_\_\_\_  
a \_\_\_\_\_ corporation, as outlined in the documents submitted pursuant to  
Florida Statutes S.628.4615, and respectfully request that the Director of the Office of  
Insurance Regulation approve the acquisition immediately.

Date:

Attest: \_\_\_\_\_ By \_\_\_\_\_  
(Name and Title) (Name and Title)

\_\_\_\_\_ By \_\_\_\_\_  
(Name and Title) (Name and Title)

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**HEALTH MAINTENANCE ORGANIZATION**

Certificate of Authority Filing Fee

(as provided under Section 624.29, F. S.)

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(Name of HMO)

Filing Fee	Amount	Type	Class	Find	Account	Source
Application	\$1,000	12	47	3	09	1

-----ATTACH YOUR CHECK HERE-----

**RETURN TO:  
DEPARTMENT OF FINANCIAL SERVICES  
BUREAU OF FINANCIAL SERVICES  
POST OFFICE BOX 6100  
TALLAHASSEE, FLORIDA 32314-6100**

# 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. \_\_\_\_\_.

SEAL

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

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

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

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

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

OIR-C1-144  
Rev 06/2004



**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/documents/industry\\_ucaa\\_third\\_party.pdf](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@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. 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@flor.com](mailto:appcoord@flor.com)



**Office of Insurance Regulation**  
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**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](http://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](http://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@flor.com](mailto:appcoord@flor.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@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**

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*Company Admissions*

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

**COMPANY  
NAME:** \_\_\_\_\_

**OFFICERS:**

**TITLES:**

**OWNERSHIP PERCENTAGE:**

**DIRECTORS:**

**SHAREHOLDERS:**

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:

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

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

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

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

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

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

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

6. List of memberships in professional societies and associations:

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

7. Present or proposed position with the Applicant 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?

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

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

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

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,

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

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

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

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.

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

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

3. Affiant's Social Security Number: \_\_\_\_\_

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

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) : \_\_\_\_\_

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

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

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

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

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