



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

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**APPLICATION FOR COMMERCIAL SELF-INSURANCE FUND**

**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.**

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
COMMERCIAL SELF-INSURANCE FUND**

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

**Section I-1** Application Fees

Applicants must pay an application fee of \$1,500 and a company license tax of \$1,000. These fees are due at the time the application package is filed, and the filing fee is NON-REFUNDABLE.

Secure your check to the INVOICE (included in this package) and send to:

Florida Department of Financial Services  
Bureau of Financial Services  
Post Office Box 6100  
Tallahassee, Florida 32314-6100

Place a copy of the INVOICE and a copy of 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 Fees

Applicants are required to pay a fee for the processing of the fingerprint cards required in section IV-5. The fingerprint cards along with the fees are due at the time the application is filed. A set of Instructions for completing the fingerprint cards is included with this package.

Secure your check to the INVOICE (included in this package) and send to:

Florida Department of Financial Services  
Bureau of Financial Services  
Post Office Box 6100  
Tallahassee, Florida 32314-6100

Place a copy of the INVOICE and a copy of the check in the management section (IV-5) of your application.

**Section I-3** Company Application for Certificate of Authority (Official Form)

On this form, list the lines of business by code (see enclosed classifications and code number form) you intend to write in the State of Florida. The lines of business listed must be consistent with the lines listed in the plan of operations submitted with this package. When a Certificate of Authority is issued by the Office of Insurance Regulation, it will

include only those lines listed on this form and addressed in the pro formas in the plan of operations. It must be signed (original signatures) by both the President or Chief Executive Officer and the Secretary of the company.

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
COMMERCIAL SELF-INSURANCE FUND**

**SECTION II - LEGAL**

**THE OFFICE OF INSURANCE REGULATION RECOMMENDS THAT CORPORATE DOCUMENTS BE REVIEWED BY YOUR LEGAL COUNSEL. THE OFFICE IS A FILING AGENCY AND AS SUCH DOES NOT RENDER ANY LEGAL, ACCOUNTING OR TAX ADVICE. THE PROFESSIONAL ADVICE OF YOUR LEGAL COUNSEL TO ASCERTAIN EXACT COMPLIANCE WITH ALL STATUTORY REQUIREMENTS IS STRONGLY RECOMMENDED. A PORTION OF THE FLORIDA STATUTES CHAPTER 624 DEALING WITH COMMERCIAL SELF-INSURANCE FUNDS IS INCLUDED IN THIS PACKAGE.**

**Section II-1** Consent and Agreement in re Service of Process (Official Form)

The Consent and Agreement in re Service of Process form (form attached) is to be accompanied by the Resolution of the Board of Trustees authorizing execution thereof (Section II-2). **NO** other signature will be accepted other than that of the Chairman of the Board of Trustees which must be under seal.

**Section II-2** Resolution Form - (Consent and Agreement in re Service of Process Official Form)

This resolution (form attached) gives specific authority to the Chairman of the Board of Trustees to execute the agreement. The enclosed Office of Insurance Regulation Resolution Form must be used. Individualized or amended forms are unacceptable. **NO** other signatures will be accepted other than those of the Chairman of the Board of Trustees and Secretary which must be under seal.

**Section II-3** Proposed Constitution, Bylaws and/or Trust Agreement

Submit unexecuted copies of the proposed constitution, bylaws and/or trust agreement. The constitution, bylaws, or trust agreement shall contain a provision prohibiting any distribution of surplus or profit except to members of the fund, as approved by the Department pursuant to s. 624.473.

**Section II-4** Indemnity Agreement

Submit copies of properly executed indemnity agreements binding each fund member to individual, several, and proportionate liability as set forth in s. 624.472 and 624.474.

**Section II-5** Sponsoring Organization

Submit the following documents from the sponsoring organization:

- (a) Certified Articles of Incorporation as received from the Secretary of State **(The Originals)**.
- (b) A Certificate of Status from the Secretary of State. (The Original).
- (c) A **Certified** copy of the bylaws or constitution signed, dated, and sealed by Secretary of the sponsoring organization.
- (d) A brief history of the sponsoring organization including: the type of association or entity (trade association, professional association, industry association, or self insurance trust fund), the address and phone number of the sponsoring organization, the date the sponsor was incorporated, and whether or not the sponsor has been in continuous operation since the date of organization.

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
COMMERCIAL SELF-INSURANCE FUND**

**SECTION III - FINANCIAL**

**Section III-1** Statutory Deposit

Pursuant to Section 624.466 (9), a Commercial Self-Insurance Fund shall be required to file a statutory deposit with the Office for the protection of the insurer's policyholders and creditors. This deposit shall have at all times a value of not less than \$100,000. In lieu of a deposit, a fund may file with the Office a surety bond in a like amount (official surety bond form attached).

Contact the Bureau of Collateral Management, Insurance Deposits Section, (850) 413-3167 for the procedures involved in establishing a deposit.

Include a verification from the Bureau of Collateral Management that the funds have been deposited or the surety bond.

**Section III-2** Verification of Funds

At least 10 days prior to the proposed effective date of the issuance of any policy, the trustees shall submit proof that the members have paid into a common claims fund in a designated depository cash premiums in an amount not less than \$50,000 or 10% of the estimated annual premium of the members at the inception, whichever is greater.

**The funds must be verified by a letter from an officer of the financial institution where the funds are being held and should include the following:**

1. Name of depositor and Federal ID Number.
2. Account numbers and amounts of funds in each account.
3. Form of funds on deposit.
4. Any restrictions on the withdrawal of the funds.

**Section III-3** Plan of Operation

It is important for the Office to have a clear understanding of the proposed operations of the new insurer and the goals it seeks to achieve. To meet this requirement the applicant shall furnish a three-year Plan of Operations. If the applicant company is owned or controlled by a Financial Institution as defined in Section 626.9885, Florida Statutes, please refer to restrictions outlined in this statute when developing the Plan of Operations. A copy of this statute is included with this package. The plan must include all major areas of the

proposed operations including but not limited to the following:

- (A) A brief description of the management experience of each individual (by name) involved in the following areas: Marketing, Underwriting, Rating, Reserving, Reinsurance, Claims Handling, Accounting, Investments, and Managing General Agents.
- (B) Description of each line of insurance products to be marketed and planned dates of initial marketing of each line.
- (C) A three year plan of marketing, including commission rates, use of brokering agents, third party administrators, and other administrative expenses.
- (D) Provide planned use of reinsurance including the purpose of the reinsurance and the degree to which it is to be used in relation to the amount of insurance in force. Include copies of policies and agreements. These should detail retentions and limits of liability for the proposed reinsurance as well as catastrophe and coverage of the largest amount retained on one risk.
- (E) Submit a statement regarding any planned changes in operations during the next three years. If no changes are planned, a statement to that effect.
- (F) Provide a list of all assumptions used in projections and pro formas and disclose how these assumptions were derived. The assumptions should at least address how the premium levels have been derived, commission rates, investment income yields, expense levels, and benefits payable under accident and health policies and contracts.
- (G) Furnish pro forma statutory balance sheet and statutory income and expense statements covering the accounts in the Exhibit A format on the attached forms (5-22). If you should have any questions concerning individual line items please refer to the NAIC instructions to the annual statement.
- (H) Furnish a list of all consultant and expert services in use or proposed during the three year period.
- (I) Provide planned premium volume for countrywide premium and Florida premium by line of insurance at three month intervals for a three year period from initial marketing date for each line of insurance.

The Plan of Operation should also include a statement prepared by an actuary who is a member of the American Academy of Actuaries or the Casualty Actuarial Society establishing that the fund has prepared a plan of operation which is based on sound actuarial principles.

#### **Section III-4** Membership Applications

Submit a membership application for each member applying for coverage with the Fund. Each of the charter members must submit a completed application.

#### **Section III-5** Financial Statements

Submit a current financial statement for each of the charter members of the Fund. Each of the charter members must submit a financial statement.

#### **Section III-6** Previous Florida Business History of Parent Company

In this section the parent company (if applicable) should detail any history that it has had in withdrawing from Florida as a whole or in discontinuing a particular line of business in this state.

#### **Section III-7** Fidelity Bond

Pursuant to section 624.466(11) a bond (or insurance policy) in the amount of no less than 10% of the funds handled annually and issued in the name of the fund covering its trustees, employees, administrator, or other individuals managing or handling the funds or assets of the fund.

#### **Section III-8** Contract Between Proposed Fund and Agent

Submit a complete copy of any contracts between the proposed fund and any agent(s).

#### **Section III-9** Administrators Agreement

Submit a complete copy of any proposed contract(s) or agreements between the proposed fund and the administrator.

#### **Section III-10** Policies and Endorsements

You are not required to have your policy rates approved as a condition precedent to receiving a license. These forms and rates may be submitted anytime after filing for the Certificate of Authority and **MUST** be approved prior to transacting any business. Submissions should be sent/linked to <https://iportal.fdfs.com/ifile/default.asp>

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
COMMERCIAL SELF-INSURANCE FUND**

**SECTION IV - MANAGEMENT**

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

**Section IV-1** Trustees and Administrator Listing

Submit a list (official form) listing the names of all trustees and officers or directors of the administrator and their relationship (owner, partner, officer, director, or employee) to the fund. If the administrator is a partnership, then information should be submitted for all partners.

**Section IV-2** Biographical Affidavits as to each Trustee of the proposed Fund and officer or director of the proposed Administrator (Official Form Enclosed).

A biographical affidavit (**Official Florida Form Only!**) must be completed for each person listed in Section IV-1. All questions must be answered and yes answers must be accompanied by an explanation. Each BIOGRAPHICAL AFFIDAVIT must contain the original signature of the respective trustee, officer, or director with an original notary seal. **Please file an original of each Biographical Affidavit for each person in the order of listing in Section IV-1.**

The requirements for the affiant's social security as part of the Biographical Affidavit is mandatory. However, pursuant to sections 119.0721(1) and (8), 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 1 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 119.0721(8), 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.

**Section IV-3** Authority for Release of Information (Official Form Enclosed)

An Authority for Release of Information form must be completed for each person listed in Section IV-1 using the attached form. Each Authority for Release form must contain an original signature of the respective trustee, officer or director and an original notary seal. **Please file an original of each Authority for Release of Information Form for each person in the order of listing in Section IV-1.**

**Section IV-4** Investigative Background Report

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

**Section IV-5** Fingerprint Cards

Fingerprint cards must be completed for each person listed in section IV-1. The fingerprint cards along with the fees are due at the time the application is filed. **No fingerprint 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. A set of instructions for completing the fingerprint cards is included with this package.

PLEASE NOTE: Information which has been entered on the cards may not be altered in any way, i.e., erased, covered with correction fluid, marked out, etc. In addition, cards may not be folded, stapled, torn or marred in any way.

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
COMMERCIAL SELF-INSURANCE FUND**

**CHECK LIST**

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

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

<u>Item #</u>	<u>Completion Check List</u>
1. Insurer application fees paid .....	<input type="checkbox"/>
(a) Copy of invoice included.....	<input type="checkbox"/>
(b) Copy of check .....	<input type="checkbox"/>
2. Fingerprint fees paid (If Applicable) .....	<input type="checkbox"/>
(a) Copy of invoice included.....	<input type="checkbox"/>
(b) Copy of check .....	<input type="checkbox"/>
3. Company Completed Application for License (Official Form) .....	<input type="checkbox"/>
(a) All classes of insurance to be transacted listed by code number ....	<input type="checkbox"/>
(b) Sealed by Company .....	<input type="checkbox"/>
(c) Signed by (original signatures)	
1. Chairman of Board of Trustees .....	<input type="checkbox"/>
2. Secretary .....	<input type="checkbox"/>

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
COMMERCIAL SELF-INSURANCE FUND**

**SECTION II - LEGAL DOCUMENTS**

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

<u>Item #</u>	<u>Completion Check List</u>
1. Consent and Agreement in re Service of Process .....	<input type="checkbox"/>
(a) Signed by Chairman of Board of Trustees .....	<input type="checkbox"/>
(b) Signed by Secretary .....	<input type="checkbox"/>
(c) Sealed with company seal.....	<input type="checkbox"/>
(d) Original.....	<input type="checkbox"/>
2. Resolution Form.....	<input type="checkbox"/>
(a) Signed by Chairman of Board of Trustees .....	<input type="checkbox"/>
(b) Signed by Secretary .....	<input type="checkbox"/>
(c) Sealed with company seal.....	<input type="checkbox"/>
(d) Original.....	<input type="checkbox"/>
3. Proposed Constitution/Bylaws .....	<input type="checkbox"/>
(a) Unexecuted.....	<input type="checkbox"/>
(b) Original.....	<input type="checkbox"/>
(c) Three copies .....	<input type="checkbox"/>

**COMMERCIAL SELF-INSURANCE FUND  
SECTION II – LEGAL DOCUMENTS, PAGE TWO**

- 4. Indemnity Agreement.....
- (a) Executed .....
- (b) Originals.....
- 5. Sponsoring Organization Documents
- (a) Articles of Incorporation (certified originals) .....
- (b) Certificate of Status (original) .....
- (c) Copy of Bylaws or Constitution.....
- (d) Miscellaneous statements .....

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
COMMERCIAL SELF-INSURANCE FUND**

**SECTION III- FINANCIAL**

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

<u>Item #</u>	<u>Completion Check List</u>
1. Verification of Statutory Deposit.....	<input type="checkbox"/>
(a) Letter from Collateral Management showing amount of deposit .....	<input type="checkbox"/>
2. Verification of Funds on Deposit.....	<input type="checkbox"/>
(a) Letter from financial institution showing:	
(1) Amount of Deposit.....	<input type="checkbox"/>
(2) Name of Depositor .....	<input type="checkbox"/>
(3) Federal ID number .....	<input type="checkbox"/>
(4) Form of funds .....	<input type="checkbox"/>
(5) Account numbers .....	<input type="checkbox"/>
(6) Amount in each account.....	<input type="checkbox"/>
(7) Any restrictions on withdrawals.....	<input type="checkbox"/>
3. Plan of Operations (two copies).....	<input type="checkbox"/>
4. Membership Application for each member.....	<input type="checkbox"/>
5. Current Financial Statement for each member .....	<input type="checkbox"/>
6. Previous Florida Business History Statement .....	<input type="checkbox"/>

**COPMMERCIAL SELF INSURANCE FUND  
SECTION III – FINANCIAL, PAGE TWO**

- 7. Copy of Fidelity Bond required in section 624.466(11) .....
- 8. Copy of contract between Fund and Agent(s).....
- 9. Administrators Agreement .....
- 10. Policies and Endorsements submitted as directed.....

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
COMMERCIAL SELF-INSURANCE FUND**

**SECTION IV- MANAGEMENT**

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

<u>Item #</u>	<u>Completion Check List</u>
1. Listing of all Trustees of Fund and Officers and Directors of Administrator (Official Form) .....	<input type="checkbox"/>
(a) Full names listed .....	<input type="checkbox"/>
(b) Titles listed .....	<input type="checkbox"/>
2. Biographical affidavits as to Trustees of Fund and Officers and Directors of Administrator (Official Form) .....	<input type="checkbox"/>
As to each biographical:	
(a) All blanks filled in .....	<input type="checkbox"/>
(b) Yes answers explained.....	<input type="checkbox"/>
(c) Contains original signature of each respective officer, director or trustee .....	<input type="checkbox"/>
(d) Notarized (Original).....	<input type="checkbox"/>
(e) Submitted original of each affidavit.....	<input type="checkbox"/>
3. Authority for Release of Information as each Trustee of the Fund and officer and director of the Administrator (Official Form) .....	<input type="checkbox"/>
(a) Contains original signature of each respective officer, director or trustee.....	<input type="checkbox"/>

**COMMERCIAL SELF INSURANCE FUND  
SECTION IV – MANAGEMENT, PAGE TWO**

- (b) Notarized (original).....
- (c) Submitted original of each release form.....
- 4. Background investigation reports for persons listed in Section IV-1 .....
- 5. Fingerprint cards enclosed for each person listed in section IV-1 (If applicable)..... 
  - (a) Contains original signature of each respective officer, director or trustee.....
  - (b) Office of Insurance Regulation card only .....
  - (c) No erasures or alterations on cards .....
  - (d) All blanks filled in .....

**INVOICE**

**DEPARTMENT OF FINANCIAL SERVICES  
OFFICE OF INSURANCE REGULATION  
COMMERCIAL SELF-INSURANCE FUND**

**APPLICATION FOR CERTIFICATE OF AUTHORITY  
COMMERCIAL SELF-INSURANCE FUND**

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

**FEIN** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**CITY, STATE & ZIP CODE:** \_\_\_\_\_

**PHONE NUMBER:** \_\_\_\_\_

**ADDRESS (IF DIFFERENT FROM COMPANY ADDRESS)**

\_\_\_\_\_

\_\_\_\_\_

(CITY) (STATE) (ZIP CODE)

1. Make payable to the Florida Department of Financial Services and mail check and invoice only 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 Department of Financial Services, Office of Insurance Regulation, Applications Section, Larson Building, Tallahassee, Florida 32399-0332.

TYPE: 10 CLASS: 30 Company License Tax \$1,000.00

TYPE: 10 CLASS: 06 Filing Fee \$1,500.00

Total \$2,500.00

DEPARTMENT OF FINANCIAL SERVICES  
OFFICE OF INSURANCE REGULATION  
TALLAHASSEE, FLORIDA 32399-0300

APPLICATION FOR LICENSE TO CONDUCT BUSINESS IN THE STATE OF FLORIDA  
(Commercial Self-Insurance Fund)

\_\_\_\_\_, 20\_\_\_\_

TO THE DIRECTOR, OFFICE OF INSURANCE REGULATION,  
TALLAHASSEE, FLORIDA

SIR: The \_\_\_\_\_  
(Give name of proposed Fund)

Federal Identification Number \_\_\_\_\_

of \_\_\_\_\_  
(Home Office Address) (City) (State) (Zip)

Phone Number \_\_\_\_\_

through its duly authorized officers, hereby applies for license authorizing and empowering the Company or Association aforesaid to transact the following kinds of insurance or branches of business in the State of Florida, under the laws thereof, during the year ending May 31, 20\_\_\_\_.

Class of Business

Code Number

By \_\_\_\_\_  
Chairman Board of Trustees

Attest \_\_\_\_\_  
Secretary

**FLORIDA DEPARTMENT OF FINANCIAL SERVICES  
OFFICE OF INSURANCE REGULATION  
PROPERTY AND CASUALTY INSURERS  
LINES OF BUSINESS BY COMPANY CODE**

- 0010 Fire
- 0020 Allied Lines
- 0030 Farmowners Multi Peril
- 0040 Homeowners Multi Peril
- 0050 Commercial Multi Peril
- 0080 Ocean Marine
- 0090 Inland Marine
- 0100 Financial Guaranty
- \*0106 Auto Warranties
- 0110 Medical Malpractice
- 0120 Earthquake
- 0160 Workers' Compensation
- 0170 Other Liability
- \*0173 Prepaid Legal
- 0192 Private Passenger Auto Liability
- 0194 Commercial Auto Liability
- 0211 Private Passenger Auto Physical Damage
- 0212 Commercial Auto Physical Damage
- 0220 Aircraft
- 0230 Fidelity
- 0240 Surety
- \*0245 Bail Bonds
- 0250 Glass
- 0260 Burglary and Theft
- 0270 Boiler and Machinery
- 0280 Credit
- \*0285 Title (Title Companies Only)
- \*0290 Livestock
- 0300 Industrial Fire
- \*0310 Mortgage Guaranty
- 0441 Credit Disability
- \*0450 Accident and Health
- \*0520 Industrial Extended Coverage
- \*0540 Mobile Home Multi Peril
- \*0550 Mobile Home Physical Damage
- \*0570 Crop Hail
- \*0607 Home Warranties
- \*0608 Service Warranties
- \*0610 Other Warranty
- \*0620 Miscellaneous Casualty

\*For purposes of applicant's plan of operations, these lines should be listed as "all other lines". If any are combined with other lines on the pro forma's (i.e. mobile home combined with homeowners), the plan of operations should specify that this was done.

**LINES OF BUSINESS BY COMPANY CODE (REINSURANCE)**

R010 Reinsurance - Fire  
R020 Reinsurance - Allied Lines  
R030 Reinsurance - Farmowners Multi Peril  
R040 Reinsurance - Homeowners Multi Peril  
R050 Reinsurance - Commercial Multi Peril  
R080 Reinsurance - Ocean Marine  
R090 Reinsurance - Inland Marine  
R100 Reinsurance - Financial Guaranty  
\*R106 Reinsurance - Auto Warranties  
R110 Reinsurance - Medical Malpractice  
R120 Reinsurance - Earthquake  
R160 Reinsurance - Workers' Compensation  
R170 Reinsurance - Other Liability  
\*R173 Reinsurance - Prepaid Legal  
R192 Reinsurance - Private Passenger Auto Liability  
R194 Reinsurance - Commercial Auto Liability  
R211 Reinsurance - Private Passenger Auto Physical Damage  
R212 Reinsurance - Commercial Auto Physical Damage  
R220 Reinsurance - Aircraft  
R230 Reinsurance - Fidelity  
R240 Reinsurance - Surety  
\*R245 Reinsurance - Bail Bonds  
R250 Reinsurance - Glass  
R260 Reinsurance - Burglary and Theft  
R270 Reinsurance - Boiler and Machinery  
R280 Reinsurance - Credit  
\*R290 Reinsurance - Livestock  
R300 Reinsurance - Industrial Fire  
\*R310 Reinsurance - Mortgage Guaranty  
R441 Reinsurance - Credit Disability  
\*R450 Reinsurance - Accident and Health  
\*R520 Reinsurance - Industrial Extended Coverage  
\*R540 Reinsurance - Mobile Home Multi Peril  
\*R550 Reinsurance - Mobile Home Physical Damage  
\*R570 Reinsurance - Crop Hail  
\*R607 Reinsurance - Home Warranties  
\*R608 Reinsurance - Service Warranties  
\*R610 Reinsurance - Other Warranty  
\*R620 Reinsurance - Miscellaneous Casualty

**CONSENT AND AGREEMENT IN RE SERVICE OF PROCESS  
FOR COMMERCIAL SELF-INSURANCE FUND**

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

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

Know all men by these presents, that the \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

a Commercial Self-Insurance Fund duly organized and existing under and by virtue of the Laws of the State of Florida, does hereby agree and consent that actions may be commenced against it in the proper Court of 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 as ex officio Insurance Commissioner, hereby stipulating and agreeing that such service shall be taken and held in all Courts to be as valid and binding upon this fund as if personal service has been made upon the trustees or any other duly authorized and accredited officer thereof. Hereby further agreeing and stipulating that this consent and agreement is and shall remain irrevocable, so long as there is liability, under any policy or claim, within this State, either fixed or contingent. Said Fund does hereby designate \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

as the name and address of the person to whom process against it served upon said Chief Financial Officer is to be forwarded. In the event of a change in the designation of the person to whom process is to be forwarded, the fund shall file same with the Chief Financial Officer.

In witness thereof, I, Chairman of the Board of Trustees of said fund has hereunto set my hand on this the

\_\_\_\_\_ day of \_\_\_\_\_ A.D. 20 \_\_\_\_\_

SEAL

By: \_\_\_\_\_  
Chairman of the Board of Trustees

The foregoing agreement must be accompanied by a duly certified copy of the order or resolution of the trustees of the fund authorizing the Chairman to execute the same for and on behalf of the fund.

**RESOLUTION FORM  
FOR COMMERCIAL SELF-INSURANCE FUND**

I hereby certify that the following resolution was adopted by the entire Board of Trustees of

\_\_\_\_\_

\_\_\_\_\_

At a meeting held by the Trustees of the Commercial Self-Insurance Fund on the  
\_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_:

"Resolved, that the Chairman of the Board of Trustees of this Fund is hereby authorized to execute, for and on behalf of this fund, the attached Consent and Agreement in Re Service of Process under the laws of Florida."

\_\_\_\_\_  
Trustee

\_\_\_\_\_  
Trustee

\_\_\_\_\_  
Trustee

\_\_\_\_\_  
Trustee

\_\_\_\_\_  
Trustee

\_\_\_\_\_  
Trustee

**State of Florida  
Department of Financial Services  
Office of Insurance Regulation**

Bond Number \_\_\_\_\_

KNOW ALL MEN BY THESE PRESENTS, THAT \_\_\_\_\_ AS  
PRINCIPAL, (Hereinafter referred to as "the Principal") and \_\_\_\_\_ AS SURETY,  
(Hereinafter referred to as "the Surety"), are held and firmly bound unto TOM GALLAGHER, Chief Financial  
Officer of the State of Florida, and his successors in office, in the sum of ONE HUNDRED THOUSAND  
DOLLARS (\$100,000) in lawful money of the United States, to the payment whereof we hereby bid  
ourselves, jointly and severally, and our successors assigns and representatives.

Signed and sealed this \_\_\_\_\_ day of \_\_\_\_\_ A.D. 20 \_\_\_\_\_.

THE CONDITION OF THE ABOVE OBLIGATION IS, THAT, WHEREAS, by virtue of Section 624.466(9),  
Florida Statutes, the above bounded, the Principal herein named, is required to deposit acceptable  
securities with a value of ONE HUNDRED THOUSAND DOLLARS (\$100,000) of a surety company  
authorized to do business in the State of Florida, said bond and company to be approved by said Chief  
Financial Officer of the State of Florida to be held by the said Chief Financial Officer of the State of Florida  
the faithful performance of its obligations to all parties to insurance contracts issued by the Commercial Self-  
Insurance Fund and its obligations under Chapter 624, Florida Statutes, by said principal herein named, in  
the State of Florida.

AND WHEREAS, the above bounden, the Principal herein named, has elected to give such surety bond with  
the Surety above named:

NOW THEREFORE, if the said Principal named herein shall faithfully perform its obligations to all parties to  
insurance contracts issued by the Commercial Self-Insurance Fund and its obligations under Chapter 624,  
Florida Statutes, or otherwise imposed upon it by the Laws of the State of Florida, then and in that event this  
bond shall be null and void.

IT IS FURTHER expressly understood and agreed by and between the parties hereto, that this bond may  
not be cancelled or released until after 30 days notice in writing to the Chief Financial Officer of the State of  
Florida provided such cancellation shall not release said Surety from any liability existing hereunder at the  
time of the effective date of said cancellation.

THE SURETY does hereby grant a period of twelve (12) months from the effective date of said cancellation  
or release in which to discover any obligation it may have had under this bond.

IN WITNESS WHEREOF, the said parties hereunto have caused to be set the hands of their respective  
proper officers and to be affixed there respective corporate seal this \_\_\_\_\_ day of \_\_\_\_\_,  
A.D. 20 \_\_\_\_\_.

Signed and sealed in the presence of:

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

By: \_\_\_\_\_  
\_\_\_\_\_

Executed at \_\_\_\_\_  
Florida, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

By \_\_\_\_\_  
Florida Resident Agent of Surety Company

NOTE: Attach to this bond a properly certified copy of the Agent's Power of Attorney

**FLORIDA DEPARTMENT OF FINANCIAL SERVICES  
OFFICE OF INSURANCE REGULATION  
MANAGEMENT INFORMATION FORM  
COMPLETE LISTING OF OFFICERS  
DIRECTORS, AND SHAREHOLDERS (10% OR MORE)**

**OFFICERS:**

**TITLES:**

**OWNERSHIP PERCENTAGE:**

**DIRECTORS:**

**SHAREHOLDERS:**





**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**  
**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](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**

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>

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