



Office of Insurance Regulation
Company Admissions

**APPLICATION FOR CERTIFICATE OF AUTHORITY
MEDICARE PLUS CHOICE PROVIDER SPONSORED ORGANIZATIONS
(PSO)**

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

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

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

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

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

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

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

In order for a submission to be considered a complete application, all required information must be included in the filing. Filings that do not include all required information will be disapproved or returned.

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In order to qualify as a Medicare Plus Choice Provider Sponsored Organization, an entity must:

- A. Be a public or private entity;
- B. Be established, or organized and operated, by a health care provider or group of affiliated health care providers;
- C. Provide a substantial proportion of the health care items and services (pursuant to the Medicare Plus Choice program) directly through the provider or affiliated group of providers; and affiliated providers share, directly or indirectly, substantial financial risk for the provision of such items and services and have at least a majority financial interest in the entity.
- D. Be a participant in the Federal Medicare Plus Choice program.
- E. Only cover Medicare Plus Choice recipients.

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

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INSTRUCTIONS

SECTION I - APPLICATION FEES AND FORM

Section I-1 Application Fee

The application filing fee is \$1,000.

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

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

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

Section I-2 Fingerprint Processing Fees

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

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

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

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

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

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

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SECTION II - LEGAL

Section II-1 Articles of Incorporation

Include in this section the applicant's Articles of Incorporation and all amendments. The required filings must be recently certified by the official public records custodian in the applicant's state of domicile. The certification letter must be an original.

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

If the entity is incorporated, submit an original certificate of status by the Florida Secretary of State's office demonstrating that the company is in good standing.

Section II-3 Company Bylaws

Include a copy of the corporation's By-Laws, Constitution, and/or Rules and Regulations in this section. The bylaws must be sealed, signed and dated by the Secretary of the company. No signatures other than the Secretary's will be accepted. The Secretary's statement must also be recently dated.

Section II-4 Health Care Provider Certificate

Submit documentation demonstrating that the entity has filed an application for a Health Care Provider Certificate to be issued by the Agency for Health Care Administration (AHCA). Documentation may be provided in the form of an acknowledgement from the Agency for Health Care that they have received the application.

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

Section II-5 Authorization Letter

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

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Section II-6 Medicare Plus Choice Contract

Prior to commencing operations, the Medicare Plus Choice Provider Sponsored Organization must provide the Office of Insurance Regulation with a copy of its Medicare Plus Choice contract with the Health Care Financing Administration (HCFA).

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SECTION III - FINANCIAL AND RELATED INFORMATION

Section III-1 Financial Requirements

A. Provide a copy of the most recent audited certified public accountant's report, if applicable. If the applicant is a development stage company that has not begun operations, an audited balance sheet should be provided. The financial statements should reflect sufficient surplus to meet the following requirements:

(1) Initial Net Worth

Minimum net worth amount: \$1.5 million, unless documentation is provided from HCFA authorizing a reduced minimum net worth of \$1 million.

Amount to be met by cash or cash equivalents: \$750,000.

(2) Continuing Net Worth Requirements

A minimum net worth amount equal to the greater of:

- a) One million dollars;
- b) Two percent of annual premium revenues as reported on the most recent annual financial statement filed with the Office of Insurance Regulation for up to and including the first \$150,000,000 of annual premiums and 1 percent of annual premium revenues on premiums in excess of \$150,000,000;
- c) An amount equal to the sum of three months of uncovered health care expenditures as reported on the most recent financial statement filed with the Office of Insurance Regulation; or
- d) Using the most recent annual financial statement filed with the Office of Insurance Regulation, an amount equal to the sum of:
 - Eight percent of annual health care expenditures paid on a non-capitated basis to non-affiliated providers; and
 - Four percent of annual health care expenditures paid on a capitated basis to non-affiliated providers plus annual health-care expenditures paid on a non-capitated basis to affiliated providers.

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- Annual health care expenditures that are paid on a capitated basis to affiliated providers are not included in the calculation of the net worth requirement.

Amount to be met by cash or cash equivalents: The greater of \$750,000 or 40 percent of the minimum net worth amount.

B. Components of Net Worth

(1) Health Care Delivery Assets:

Admit 100% of book value (GAAP depreciated value) of Health Care Delivery Assets on the balance sheet of the Medicare Plus Choice PSO.

Health Care Delivery Assets include any tangible asset that are part of the Medicare Plus Choice PSO operation, including: hospitals, medical facilities, and their ancillary equipment, and such property as may reasonably be required for the entity's principal office or for such purposes as may be necessary in the transaction of business.

(2) Intangible Assets:

Initial Calculation

- a) If at least \$1 million of the initial minimum net worth requirement is met by cash or cash equivalents, then the GAAP value of intangible assets will be admitted up to 20% of the initial minimum net worth amount required.
- b) If less than \$1 million of the initial minimum net worth requirement is met by cash or cash equivalents or is reduced to an initial net worth requirement below \$1.5 million, then the GAAP value of intangible assets will be admitted up to 10% of the minimum initial net worth amount required.

Ongoing Calculation

- a) Up to 20 percent of the minimum net worth amount will be admitted if the greater of \$1,000,000 or 67 percent of the minimum net worth amount is met by cash or cash equivalents; or
- b) Up to ten percent of the minimum net worth amount will be admitted if the greater of \$1,000,000 or 67 percent of the minimum net worth amount is not met by cash or cash equivalents.

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- (3) Subordinated Debts and Subordinated Liabilities.

Fully subordinated debt and subordinated liabilities are excluded from the calculation of an entity's net worth for purposes of meeting the minimum requirements.

- (4) Deferred acquisition costs are not admitted.

- (5) Calculation--other assets:

Other assets not used in the delivery of health care may be used for purposes of meeting the minimum net worth requirement, provided such assets are reported using Florida Statutory accounting practices.

C. Liquidity

- (1) A Medicare Plus Choice PSO must demonstrate sufficient cash flow to meet financial obligations as they become due and payable.
- (2) The Medicare Plus Choice PSO should demonstrate the methods to be utilized in meeting its cash flow obligations in the Plan's projected financial statements.
- (3) To determine whether the Medicare Plus Choice PSO continues to meet the requirement in paragraph (1) of this section, the Office will examine the following:
- a) The Medicare Plus Choice PSO's timeliness in meeting current obligations;
 - b) The extent to which the Medicare Plus Choice PSO's current ratio of assets to liabilities is maintained at 1:1 including whether there is a declining trend in the current ratio over time; and
 - c) The availability of outside financial resources to the Medicare Plus Choice PSO.
- (4) If a Medicare Plus Choice PSO fails to meet the requirements in paragraph (3)(a) of this section, the Office will require the Medicare Plus Choice PSO to initiate corrective action and pay all overdue obligations.

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- (5) If a Medicare Plus Choice PSO fails to meet the requirement of paragraph (3)(b) of this section, the PSO will be required to initiate corrective action as follows:
- a) Change the distribution of its assets;
 - b) Reduce its liabilities; or
 - c) Make alternative arrangements to secure additional funding to restore the Medicare Plus Choice PSO's current ratio to 1:1.
- (6) If a Medicare Plus Choice PSO fails to meet the requirement of paragraph (3)(c) of this section, the Medicare Plus Choice PSO will be required to obtain funding from alternative financial resources.

Section III-2 Financial Plan

A. Plan Content and Coverage:

At the time of application, the PSO must submit a financial plan demonstrating it has the resources available to cover the period through twelve-months **beyond** the projected break-even point.

A financial plan must include--

- A detailed marketing plan;
- Statements of revenue and expense on an accrual basis;
- A cash flow statement;
- Balance sheets;
- The assumptions in support of the financial plan;
- Availability of financial resources to meet projected losses.

Except for the use of guarantees as provided in section (1) below, and letters of credit as provided in section (2) below, the resources to meet projected losses must be assets on the balance sheet of the Medicare Plus Choice PSO in a form

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that is either cash or will be convertible to cash in a timely manner, pursuant to the financial plan.

- (1) Guarantees will be accepted as a resource to meet projected losses, under the following conditions:

In the first year, the guarantor must provide the Medicare Plus Choice PSO with cash or cash equivalents to fund the projected losses, as follows:

- prior to the beginning of the first quarter, in the amount of the projected losses for the first two quarters;
- prior to the beginning of the second quarter, such that the Medicare Plus Choice PSO has cash or cash equivalents sufficient to meet projected losses through the end of the third quarter; and
- prior to the beginning of the third quarter, such that the Medicare Plus Choice PSO has cash or cash equivalents sufficient to meet the projected losses through the end of the fourth quarter.

- (2) An irrevocable, clean, unconditional letter of credit may be used in place of cash or cash equivalents if deemed satisfactory to the Office of Insurance Regulation.

The financial plan must be satisfactory to the Office of Insurance Regulation. At its discretion, the Office may require the financial plan to be certified by reputable and qualified actuary.

B. Statement of Initial Cash

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

C. Deposit

Each Medicare Plus Choice Provider Sponsored Organization shall deposit with the Office of Insurance Regulation cash or securities of the type eligible under s. 625.52, which shall have at all times a market value in the amount set forth in this subsection. The amount of the deposit shall be reviewed annually, or more often, as the department deems necessary. The market value of the deposit shall be a minimum of \$300,000, up to a maximum of \$2 million.

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Section III-3 Insurance

- A. Furnish evidence of adequate insurance coverage or an adequate plan for self-insurance to respond to claims for injuries arising from the provision of health care services. If not self-insured, submit executed copies of the following policies, with the Office of Insurance Regulation listed on the policies for purposes of notification of any modification, cancellation or termination of the policies:
- (1) General liability.
 - (2) Medical malpractice or professional liability. The Medicare Plus Choice PSO must secure this coverage. The fact that the medical provider has this coverage does not release the Medicare Plus Choice PSO from the obligation to secure it. A binder for the policies along with a specimen copy of each policy can be submitted initially. Prior to licensure, executed copies of the policies must be submitted.
- B. Furnish a photocopy of an executed fidelity bond in the minimum amount of \$100,000, issued by an **authorized insurance carrier** in this State and covering all employees handling funds.
- C. Describe how the Medicare Plus Choice PSO limits or proposes to limit its financial risk. If the Medicare Plus Choice PSO secures catastrophic or reinsurance coverage, it is required to submit executed copies of the applicable policy with the Office of Insurance Regulation endorsed on the agreement as an additional insured. Each reinsurance agreement and any modifications thereto must be filed with and approved by the Office. Each such agreement must remain in full force and effect until replaced or for at least 90 days following written notification to the Office by registered mail of cancellation by either party.

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

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Section III-4 Contracts

- A. A copy of each type of contract made, or to be made, between the applicant and any providers (i.e. hospitals, physicians, physician groups) regarding the provision of health care services to enrollees.

- B. A copy of the form of any contract made or to be made between the applicant and senior management employment, as well as any person, corporation, partnership, or other entity for the performance on the applicant's behalf of any function including, but not limited to, marketing, administration, enrollment, investment management, and subcontracting for the provision of health care services to enrollees.

Section III-5 Grievance Procedure

Grievances, Coverage Determinations, Reconsiderations and Appeals--As under current law, Medicare Plus Choice plans must maintain meaningful procedures for hearing and resolving grievances.

Medicare Plus Choice plans must have a procedure for making determinations regarding whether an enrollee is entitled to receive services and the amount the individual is required to pay for such services. Determinations must be made on a timely basis. The explanation of a plan's determination must be in writing and must explain the reasons for the denial in understandable language and describe the reconsideration and appeals processes. The time period for reconsiderations would be specified by the Secretary but could not be greater than 60 days after the request by the enrollee. Reconsiderations of coverage determinations to deny coverage based on lack of medical necessity must be made by a physician with expertise in the field of medicine which relates to the condition necessitating treatment.

Plans would be required to have an expedited review process in cases where the normal time frame for making a determination or reconsideration could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. Either the beneficiary or the physician could request an expedited review. Requests for expedited reviews made by physicians (even those not affiliated with the organization) must be granted by the plan. Expedited determinations and reconsiderations must be made within time periods specified by the Secretary, but not later than 72 hours after the request for expedited review, or such longer period as the Secretary may permit in specified cases.

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The Secretary would be required to contract with an independent, outside entity to review and resolve plan reconsideration's not favorable to the beneficiary. If the independent review is unfavorable to the beneficiary, the beneficiary would have right to the same appeal process (e.g. ALJ, judicial review) as under existing HMO procedures.

Section III-6 Bankruptcy Proceedings

The following documentation must be provided:

- A. An acknowledgment that a delinquency proceeding pursuant to Part I of Chapter 631 or supervision by the Office of Insurance Regulation pursuant to s. 624.80-624.87, Florida Statutes, constitutes the sole and exclusive method for the liquidation, rehabilitation, reorganization, or conservation of a Medicare Plus Choice Provider Sponsored Organization.

- B. A waiver of any right to file or be subject to a bankruptcy proceeding; and

- C. An acknowledgment that the commencement of a bankruptcy proceeding either by or against a Medicare Plus Choice Provider Sponsored Organization shall, by operation of law, terminate the Medicare Plus Choice PSO's certificate of authority and vest in the Office for the use and benefit of the subscribers of the Medicare Plus Choice Provider Sponsored Organization the title to any deposits of the insurer held by the Office.

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SECTION IV - MANAGEMENT

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

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

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

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

Provide a National Association of Insurance Commissioners (NAIC) biographical affidavit (OIR-C1-1423) for each officer, director or shareholder 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 officer, director or shareholder and an original notary seal. Submit the original of each biographical affidavit.

The requirement for the affiant's social security 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 1 of the Biographical Affidavit, please include the affiant's name and social security number on a separate page and attach it to the Biographical Affidavit. Also please stamp CONFIDENTIAL at the top and bottom of the separate page.

Section 119.071(5), Florida Statutes, gives authority for an agency to collect social security numbers if imperative for the performance of that agency's duties and responsibilities as prescribed by law. Limited collection of social security numbers is imperative for the Office 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

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directors of any insurer are competent and trustworthy, possess financial standing and business experience, and have not been found guilty of, or not pleaded guilty or nolo contendere to, any felony or crime punishable by imprisonment of one year.

Section IV-3 Investigative Background Reports

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

Section IV-5 Fingerprint cards

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

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

Please place the completed fingerprint cards in this section.

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

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SECTION V - HCFA MEDICARE FORMS AND RATES

Submit to the Office of Insurance Regulation an affidavit attesting to the utilization of HCFA authorized forms and rates.

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

Company Name: _____

<u>Item #</u>		<u>Completion Check List</u>
1.	Application Fees Paid	<input type="checkbox"/>
	(a) Copy of invoice included (Official Form).....	<input type="checkbox"/>
	(b) Copy of check included	<input type="checkbox"/>
	(c) Check mailed to address on Invoice	<input type="checkbox"/>
2.	Fingerprint fee paid electronically	<input type="checkbox"/>
	(a) Copy of on-line payment confirmation	<input type="checkbox"/>
	or, if applicable	
	(b) Copy of invoice included (Official Form)	<input type="checkbox"/>
	(b) Copy of check included	<input type="checkbox"/>
	(c) Check mailed to address on Invoice	<input type="checkbox"/>
3.	Deposits	<input type="checkbox"/>
	(a) Evidence of deposit with Collateral Management	<input type="checkbox"/>
4.	Application for Certificate of Authority (Official Form).....	<input type="checkbox"/>
	(a) Application form completed	<input type="checkbox"/>
	(b) Sealed by corporation.....	<input type="checkbox"/>
	(c) Signed by President and other authorized officer (original signature)	<input type="checkbox"/>
	(d) Notarized.....	<input type="checkbox"/>

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SECTION II - LEGAL

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

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SECTION III - FINANCIAL AND RELATED INFORMATION

<u>Item #</u>		<u>Completion Check List</u>
1.	Financial Statements	<input type="checkbox"/>
	(a) Current audited financial statements.....	<input type="checkbox"/>
2.	Financial Plan.....	<input type="checkbox"/>
	(a) Detailed marketing plan.....	<input type="checkbox"/>
	(b) A statement of revenue & expense on accrual basis.....	<input type="checkbox"/>
	(c) Cash flow statement	<input type="checkbox"/>
	(d) Balance sheets	<input type="checkbox"/>
	(e) Assumptions supporting financial plan	<input type="checkbox"/>
	(f) Availability of resources to meet projected losses	<input type="checkbox"/>
	(g) Statement of Initial Cash.....	<input type="checkbox"/>
	(h) History	<input type="checkbox"/>
	(i) Contingency Plans.....	<input type="checkbox"/>
	(j) Feasibility study	<input type="checkbox"/>

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<u>Item #</u>		<u>Completion Check List</u>
3.	Insurance	<input type="checkbox"/>
	(a) Copy of current general liability policy or plan for self-insurance ... and Current medical malpractice policy or plan for self-insurance	<input type="checkbox"/> <input type="checkbox"/>
	(b) Evidence of current fidelity bond	<input type="checkbox"/>
	(c) Reinsurance treaty.....	<input type="checkbox"/>
4.	Contracts	<input type="checkbox"/>
	(a) Provider contract form and signature pages	<input type="checkbox"/>
	(b) Other forms of contracts	<input type="checkbox"/>
5.	Grievance Procedure	<input type="checkbox"/>
	(a) Formal and informal steps included	<input type="checkbox"/>
6.	Bankruptcy Proceedings.....	<input type="checkbox"/>
	(a) Acknowledgement filed.....	<input type="checkbox"/>
	(b) Waiver for bankruptcy proceeding.....	<input type="checkbox"/>
	(c) Acknowledgement for bankruptcy proceeding.....	<input type="checkbox"/>

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SECTION IV - MANAGEMENT

<u>Item #</u>	<u>Completion Check List</u>
1.	Listing of all officers, directors, and stockholders, etc <input type="checkbox"/>
(a)	Separate listing of all officers and directors for the corporation (Official Form)..... <input type="checkbox"/>
(b)	Separate listing of stockholders, including percentage held and number and class of shares (Official Form) <input type="checkbox"/>
(c)	Chart of parent company <input type="checkbox"/>
2.	Biographical Statement and Affidavits as requested in Section IV-1 A and B (Official Form)..... <input type="checkbox"/>
	For each biographical affidavit:
(a)	All blanks completed <input type="checkbox"/>
(b)	"Yes" answers explained <input type="checkbox"/>
(c)	Contains original signature <input type="checkbox"/>
(d)	Notarized (original)..... <input type="checkbox"/>
(e)	Original of each affidavit submitted <input type="checkbox"/>
4.	Investigative Background Report for each individual requested in Section IV-1 A and B <input type="checkbox"/>
5.	Fingerprint cards enclosed for each person listed Section IV-1 A and B..... <input type="checkbox"/>
(a)	Contains original signature <input type="checkbox"/>
(b)	Card furnished by Office of Insurance Regulation <input type="checkbox"/>

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(c) All information completed (DOB, Citizenship,
Vital Statistics)

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SECTION V - FORMS AND RATES

<u>Item #</u>	<u>Completion Check List</u>
1. Affidavit.....	<input type="checkbox"/>

RETURN THE COMPLETED CHECKLIST WITH THE APPLICATION PACKAGE.

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Application is hereby submitted to form and operate a Medicare Plus Choice Provider Sponsored Organization.

Proposed name of Medicare Plus Choice Provider Sponsored Organization:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

FEDERAL IDENTIFICATION NUMBER: _____

PHONE: _____

SOLVENCY CONTACT PERSON: _____

ATTORNEY OR PRINCIPAL FILING THIS APPLICATION:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: _____

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

Signed this _____ day of _____, 20 _____

President or other authorized officer (please print)

(Corporate Seal)

Signature

Second authorized officer (please print)

Signature

State of _____

County of _____

Sworn to and subscribed before me

this _____ day of _____, 20 _____

Notary Public

(Notary Seal)

My Commission Expires

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INVOICE

NAME OF MEDICARE PLUS CHOICE PROVIDER SPONSORED ORGANIZATION:

FEIN: _____

ADDRESS: _____

CITY, STATE & ZIP CODE: _____

PHONE NUMBER: _____

ADDRESS (IF DIFFERENT FROM ARRANGEMENT ADDRESS)

(CITY)

(STATE)

(ZIP CODE)

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

PLEASE NOTE:

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

For Accounting Use Only

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

**FLORIDA DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
APPLICATION FOR CERTIFICATE OF AUTHORITY
MEDICARE PLUS CHOICE PROVIDER SPONSORED ORGANIZATIONS (PSO)**

**MANAGEMENT INFORMATION FORM
OFFICERS, DIRECTORS, AND SHAREHOLDERS**

COMPANY NAME: _____

NAMES:

TITLES:



Office of Insurance Regulation
Company Admissions

INSTRUCTIONS FOR FURNISHING BACKGROUND INVESTIGATIVE REPORTS

1. A background investigative report must be completed for each individual as indicated in the instructions in the application package.
2. Please refer to the NAIC website at http://www.naic.org/documents/industry_ucaa_third_party.pdf "Third Party Vendors for Background Reports", for specific information regarding background investigation vendors.
3. The applicant is responsible for paying for the reports and for handling billing arrangements with the selected vendor.
4. Applicants are required to ensure that the selected vendor will transmit investigative reports electronically to the Florida Office of Insurance Regulation ("Office") to this e-mail address: bkgrnd-inv@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



Office of Insurance Regulation
Company Admissions

FINGERPRINT PAYMENT AND SUBMISSION PROCEDURE

LiveScan (available to Florida Residents):

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

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

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

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

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

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

*Applicants must use fingerprint cards provided by the Office. Applicants must provide **two** completed cards per person. Blank fingerprint cards may be requested by emailing appcoord@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.

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