APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION

This packet is designed to assist individuals in preparing the application in accordance with Florida Statutes and Rules and to facilitate expeditious processing of the application by the Florida Office of Insurance Regulation ("Office").

Please submit all documents required by this packet in searchable PDF format unless otherwise indicated or required by Florida Statutes.

If this packet requires submission of forms or rates, upon receipt of an email notification of acceptance of the application, the Applicant is directed to return to the Industry Portal https://www.floir.com/iportal and select "Insurance Regulation Filing System (IRFS)" to begin the submission of forms and/or rates.

In order for a submission to be considered a complete application, all required information must be included in the filing, including the completed application checklist.

The completed application packet must be submitted to the Office by selecting iApply – Online Company Admissions at the following link:

https://www.floir.com/iportal

Any questions concerning this application packet or iApply for Life and Health applicants may be directed to lhappcoord@floir.com. Property and Casualty applicants are directed to pcappcoord@floir.com.

Pursuant to Section 641.2015 and 641.19, Florida Statutes, in order to qualify as a Health Maintenance Organization, an entity must:

A. Be incorporated or be a division of a corporation formed under the provisions of either chapter 607 or Chapter 617, or shall be a public entity that is organized as a political subdivision. [s. 641.2015, F.S.];

B. Provide emergency care, inpatient hospital services, physician care including care provided by physicians licensed under Chapters 458, 459, 460, and 461, ambulatory diagnostic treatment, and preventive health care services. [s.641.19(12)(a), F.S.];

C. Provide either directly or through arrangements with other persons, health care services to persons enrolled with such organization, on a prepaid per capita or prepaid aggregate fixed-sum basis. [s.641.19(12)(b), F.S.];

D. Provide either directly or through arrangements with other persons, comprehensive health care services which subscribers are entitled to receive pursuant to a contract. [s.641.19(12)(c), F.S.];

E. Provide physician services, by physicians licensed under Chapters 458, 459, 460 and 461, directly through physicians who are either employees or partners of such organization or under arrangements with a physician or any group of physicians. [s.641.19(12)(d),F.S.]; and

F. If an HMO offers services through a managed care system, then the managed care system must be a system in which a primary physician licensed under chapter 458 or Chapter 459 and Chapters 460 and 461 is designated for each subscriber upon request of a subscriber requesting service by a physician licensed under any of those chapters, and is responsible for coordinating the health care of the subscriber of the respectively requested service and for referring the subscriber to other providers of the same discipline when necessary. Each female subscriber may select as her primary physician an obstetrician/gynecologist who has agreed to serve as a primary physician and is in the health maintenance organization's provider network [s.641.19(12)(e), F.S.]

Although a pre-filing conference is not a statutory requirement, it has proven beneficial to both the applicant and the Office. To schedule a conference, please email lhappcoord@floir.com or call (850) 413-2512.

INSTRUCTIONS
SECTION I - APPLICATION FEES AND FORM

Section I-1 Application Fee

The application filing fee is $1,000. [s.641.29(1),F.S.]

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

Department of Financial Services
Revenue Processing Section
PO Box 6100
Tallahassee, Florida 32314-6100

Submit 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 Processing Fees

Applicants are required to pay a fee for the processing of the fingerprint cards required in Section IV-4. Florida residents have the option of having their fingerprints digitally scanned rather than providing paper fingerprint cards. Please see Form OIR-C1-938, Fingerprint Payment and Submission Procedure for instructions.

Section I-3 Deposits and Assessments

A. Submit a check for $10,000 made payable to "Commissioner of Insurance Regulation, State of Florida-Rehabilitation Administrative Expense Fund" to comply with Section 641.227(1), Florida Statutes. Mail the check to:

Department of Financial Services
Revenue Processing Section
PO Box 6100
Tallahassee, Florida 32314-6100

Submit a copy of the invoice and a copy of the check with your application filing.

B. Submit a check for $25,000 made payable to "Florida HMO Consumer Assistance Plan" to cover the special assessment required by Section 641.228(1), Florida Statutes. Mail the check to:

Bruce D. Platt, Plan Manager
201 E. Park Ave, Suite 300
Tallahassee, FL 32301
(850) 425-1628

Submit a copy of your transmittal letter to the Plan Manager and the check with your application filing.

Section I-4 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.

SECTION II - LEGAL

Section II-1 Articles of Incorporation

Submit Articles of Incorporation and all amendments certified by the Florida Secretary of State's office. The certification must be an original.

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

Submit an original certificate of status by the Florida Secretary of State's office demonstrating that the company is in good standing. You may contact the Florida Secretary of State's office at (850) 245-6052 for further information in obtaining this certificate.

Section II-3 Company Bylaws

Submit a copy of the company's bylaws, rules and regulations or similar form of document, if any, regulating the conduct of the affairs of the applicant. These documents must be accompanied by a Board Resolution signed and dated by the secretary of the corporation, stating that the documents are a true and correct copy. The signature must be original and under the company's corporate seal.

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) pursuant to Chapter 641, Part III, Florida Statutes. Documentation may be provided in the form of an acknowledgement from the Agency for Health Care that the application has been received by them.

NOTE: The Office 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 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.

SECTION III - FINANCIAL AND RELATED INFORMATION

Section III-1 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 HMO must secure this coverage. The fact that the medical provider has this coverage does not release the HMO 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 HMO limits or proposes to limit its financial risk. If the HMO secures catastrophic or reinsurance coverage, it is required to submit executed copies of the applicable policy with the Office of Insurance Regulation. Any reinsurance agreement must comply with Section 624.610, Florida Statutes and Rule Chapter 69O-144, Florida Administrative Code.

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 HMO and providers.

Section III-2 Financial Statements

A. Provide a copy of the most recent audited certified public accountant's report prepared on the basis of statutory accounting principles. 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 requirements of s. 641.225, Florida Statutes.

B. Provide all quarterly financial statements covering the current year-to-date reporting period signed by the company's officers under notary seal.

Section III-3 Plan of Operations

Provide a statement generally describing present and proposed operations. State whether the HMO will be organized for profit or not for profit and whether it will be a Staff Model, IPA Model, or Combination Model HMO. Also, identify the HMOs fiscal year end date. The plan of operations should be for the greater of three years or until the health maintenance organization has been projected to be profitable for twelve consecutive months.

If the HMO intends to market to small groups as defined by the Employee Health Care Access Act, s. 627.6699, Florida Statutes, please complete and submit the attached small employer carrier's application.

If the plan of operation indicates that the HMO will receive Medicaid funds, list all contracts and agreements and any information relative to any payment or agreement to pay, directly or indirectly, a consultant fee, a broker fee, a commission, or other fee or charge related in any way to the application for a certificate of authority or the issuance of a certificate authority. Such list shall provide the following, including, but not limited to, the name of the person or entity paying the fee; the name of the person or entity receiving the fee; the date of payment; and a brief description of the work performed.

Section III-3(a) Marketing and Growth

Submit a description of the proposed method of marketing, including the target groups, types of coverage to be offered, and advertising media to be used. Include a statement describing with reasonable certainty the geographic area or areas to be served by the HMO. Identify competing HMOs operating in the same geographic service area, as well as the market penetration of each. Also, identify the major differences between the applicant HMO and its competitors.

Section III-3(b) Pro Forma Statements

Submit a pro forma balance sheet and income statement on a statutory basis at monthly intervals (with an annual total) for a minimum three-year period (greater of three years or until the health maintenance organization has been projected to be profitable for twelve consecutive months.) All assumptions used in deriving the pro forma statements must be provided. A Statement of Changes in Financial Position and a Statement of Cash Flows should be provided for the three-year period (or break-even), as well.

Section III-3(c) 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.

Section III-3(d) History

Provide a brief history of the company since its incorporation. Include any predecessor corporations or organizations, mergers, reorganizations, or changes of ownership. Specify the parties and dates involved.

Section III-3(e) Insolvency Protection

Provide the method in which the applicant will comply with the insolvency protection requirements of Section 641.285, Florida Statutes, including all relevant documentation necessary to meet the requirements. Each HMO must comply with the insolvency protection requirements of Florida law. This is accomplished through a deposit with the Office of Insurance Regulation in the amount of $300,000.00.

Section III-3(f) Contingency Plans

Provide any contingency plans for additional capital should the HMO fail to maintain minimum surplus requirements as mandated by Section 641.225, Florida Statutes.

Section III-3(g) Feasibility Study

Submit a comprehensive feasibility study, performed by a certified actuary in conjunction with a certified public accountant, which includes a rate and financial analysis, as well as enrollment projections and assumptions and competitor information. The study shall be for the greater of three years or until the HMO has been projected to be profitable for twelve consecutive months. The study shall show that the HMO will maintain, at all times, the minimum surplus required by Section 641.225, Florida Statutes, and will not, at the end of any month of the projection period, have less than the minimum surplus as required by Section 641.225, Florida Statutes. The feasibility study shall contain an opinion by the CPA and actuary performing the study which shall opine as to the reasonableness of the assumptions used in the feasibility study and that the assumptions are reasonably applied.

The financial portion of the study shall be prepared in accordance with standards promulgated by the American Institute of Certified Public Accountants in its "Guide for Prospective Financial Statements" and opined accordingly. The actuarial portion of the study shall be prepared in accordance with standards promulgated by the American Academy of Actuaries and opined accordingly. The feasibility study shall contain nothing less than an "examination opinion."

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. All such contracts shall comply with Section 641.315, Florida Statutes.

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. All such contracts shall comply with Section 641.234, Florida Statutes and 641.315, F.S. if applicable.

Section III-5 Grievance Procedure

A statement describing the HMO's grievance procedure that will facilitate the resolution of subscriber grievances. The grievance procedure must include both formal and informal steps for resolving grievances and must be in compliance with all requirements set forth in Rule 69O-191.078, F.A.C., s.641.21(1)(e), & s. 641.22(9), F.S.

Section III-6 Bankruptcy Proceedings

Submit evidence of compliance with Section 641.215, Florida Statutes. This documentation should contain:

A. An acknowledgment that a delinquency proceeding pursuant to Part I of Chapter 631 or supervision by the Office pursuant to s. 624.80-624.87, Florida Statutes, constitutes the sole and exclusive method for the liquidation, rehabilitation, reorganization, or conservation of a health maintenance 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 health maintenance organization shall, by operation of law, terminate the health maintenance organization's certificate of authority and vest in the Office for the use and benefit of the subscribers of the health maintenance organization the title to any deposits of the insurer held by the Office.

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 (Management Information Form, OIR-C1-2221).

B. List the names of each stockholder owning five percent or more of voting securities of the applicant or any person 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 HMO, including any possible conflicts of interest.

C. If the applicant is a subsidiary of a parent or holding company, provide an organizational chart showing the relationship of all related companies.

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

Provide a Biographical Affidavit (Form OIR-C1-1423) for each officer, director, and shareholder listed in Section IV-1 except for those companies in the organizational structure between the immediate parent and the ultimate parent. All questions must be answered.

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

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

Section IV-3 Background Investigative Reports

A Background Investigative 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 Form OIR- C1-905 for instructions.

Section IV-4 Fingerprint Cards

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

SECTION V - FORMS AND RATES

Note: submit three (3) original copies of each referenced form and rate filing.

Section V-1 Forms

A. Submit three copies of each policy, master contract, certificate of coverage, member handbook, application, or any other form the applicant proposes to offer the subscriber. This includes any form showing the benefits to which the subscriber is entitled and any form used in the enrollment process. Every form which the HMO will use in connection with its subscriber contracts must be submitted and must be identified by a unique form number located on the lower left corner of the form.

B. Each subscriber contract must state the procedures for offering comprehensive health care services and offering and terminating contracts to subscribers which will not unfairly discriminate on the basis of age, sex, race, handicap, health, or economic status.

Section V-2 Rates

A. Submit three copies of the complete schedule of proposed premium rates for each type of contract. The submission for each separate contract should contain an opinion from a qualified independent actuary. The opinion shall:

(1) Certify that the rates are neither inadequate nor excessive nor unfairly discriminatory;
(2) Certify that the rates are appropriate for the classes or risks for which they have been computed;
(3) Present an adequate description of the rating methodology, following consistent and equitable actuarial principles.

B. Furnish a statement from a qualified independent actuary that the HMO is actuarially sound.

APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION

CHECK LIST
SECTION I - APPLICATION FEES AND FORM

Company Name: _____

Item #			Completion Check List
1.		Application Fees Paid	☐
	(a)	Copy of invoice included (Official Form)	☐
	(b)	Copy of check included	☐
	(c)	Check mailed to address on Invoice	☐
2.		Fingerprint fee paid electronically	☐
	(a)	Copy of on-line payment confirmation	☐
3.		Deposits and Assessments	☐
	(a)	Copy of $10,000 check and copy of Invoice	☐
	(b)	Copy of $25,000 check and copy of cover letter	☐
4.		Application for Certificate of Authority (Official Form)	☐
	(a)	Application form completed	☐
	(b)	Sealed by corporation	☐
	(c)	Signed by President and other authorized officer (original signature)	☐
	(d)	Notarized	☐

SECTION II - LEGAL

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

SECTION III - FINANCIAL AND RELATED INFORMATION

Item #			Completion Check List
1.	Insurance		☐
	(a)	Copy of current general liability policy or plan for self-insurance ..... and Current medical malpractice policy or plan for self-insurance	☐ ☐
	(b)	Evidence of current fidelity bond	☐
	(c)	Reinsurance treaty	☐
2.	Financial Statements		☐
	(a)	Current audited financial statements	☐
	(b)	Quarterly financial statement	☐
3.	Plan of Operations		☐
	(Small Employer Carrier Application, if applicable)		☐
	(a)	Marketing and Growth	☐
		(1) Description of marketing methods	☐
		(2) A statement describing the applicant, facilities and personnel, etc	☐
		(3) Statement of geographic area to be served	☐

Item #			Completion Check List
(b)	Pro Forma Statements		☐
	(1)	Balance sheet	☐
	(2)	Income statement	☐
	(3)	Cash flow analysis	☐
	(4)	Change in financial position	☐
(c)	Statement of Initial Cash		☐
	Provisions for contingencies		☐
(d)	History		☐
(e)	Insolvency Protection Deposit with the Office		☐
	(1)	Deposit with the Office	☐
		or	
	(2)	Reinsurance Policy	☐
		or	
	(3)	Guarantee Arrangement	☐
(f)	Contingency Plans		☐
(g)	Feasibility study		☐
4.	Contracts		☐
(a)	Provider contract form and signature pages		☐
(b)	Other forms of contracts		☐

Item #		Completion Check List
5.	Grievance Procedure	☐
	(a) Formal and informal steps included	☐
6.	Bankruptcy Proceedings	☐
	(a) Acknowledgement filed	☐
	(b) Waiver for bankruptcy proceeding	☐
	(c) Acknowledgement for bankruptcy proceeding	☐

SECTION IV - MANAGEMENT

Item #		Completion Check List
1.	Listing of all officers, directors, and shareholders (including entities owning 10% or more of applicant (Form OIR-C1-2221).....	☐
2.	Listing of all immediate parent(s) officers, directors and shareholders (including entities) owning 10% or more of parent company's stock (Form OIR-C1-2221).	☐
3.	Listing of all intermediary parent(s) (between immediate parent(s) and ultimate parent(s)), officers and shareholders (including entities) owning 10% or more of parent company's stock (Form OIR-C1-2221). Note, do not complete Form OIR-C1-1423 (Biographical Affidavits), or order investigative reports or fingerprint cards.....	☐
4.	Listing of all ultimate parent(s) officers, directors and shareholders (including entities) owning 10% or more of parent company's stock (Form OIR-C1-2221)	☐
5.	Organizational Chart including all entities within the ultimate parent company structure	☐
6.	Biographical Affidavits for company officers, directors and shareholders (including entities) owning 10% or more of applicant (Form OIR-C1-1423) …….	☐
	As to each biographical:	
	(a) All blanks completed	☐
	(b) "Yes" answers explained	☐
	(c) Contains original signature	☐
	(d) Notarized (original)	☐
	(e) Original of each affidavit submitted…….……	☐
	(f) SSN on a separate page……	☐

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

9. Background investigative reports for company officers, directors and shareholders (including entities) owning 10% or more of applicant……. ☐

10. Background Investigative reports for immediate parent(s) officers, directors and shareholders (including entities) owning 10% or more of parent company's stock…… ☐

11. Background Investigative reports for ultimate parent(s) officers, directors and shareholders (including entities) owning 10% or more of parent company's stock…… ☐

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

As to each fingerprint card:

(a) Contains original signature ..... ☐

(b) Florida cards only ..... ☐

(c) All information completed (DOB, citizenship, vital statistics, SSN on a separate page) ..... ☐

13. Fingerprint cards enclosed for each immediate parent(s) officer, director, and shareholder (including entities) owning 10% or more of parent company's stock..... ☐

As to each fingerprint card:

(a) Contains original signature ..... ☐

(b) Florida cards only ..... ☐

(c) All information completed (DOB, citizenship, vital statistics, SSN on a separate page) ..... ☐

14. Fingerprint cards enclosed for each ultimate parent(s) officer, director, and shareholder (including entities) owning 10% or more of parent company's stock..... ☐

As to each fingerprint card:

(a) Contains original signature ..... ☐

(b) Florida cards only .. .. ☐

(c) All information completed (DOB, citizenship, vital statistics, SSN on a separate page) ..... ☐

SECTION V - FORMS AND RATES

Item #			Completion Check List
1.	Forms		☐
	(a)	3 copies of each form	☐
	(b)	Identified by unique form number	☐
2.	Rates		☐
	(a)	3 copies of each rate schedule and or contract placed with original application	☐
	(b)	Rates are neither inadequate, excessive, nor unfairly discriminatory	☐
	(c)	Rates are appropriate for class	☐
	(d)	Description of rating methodology	☐
	(e)	Statement from a qualified actuary that the HMO is actuarially sound	☐

APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION

CHECKLIST VERIFICATION

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

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

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

_____
Signature of President, Secretary, or Treasurer

_____ _____
Printed Name Printed Title

RETURN THE COMPLETED CHECK LIST WITH THE APPLICATION PACKAGE.

APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION

Pursuant to Chapter 641, Part I, Florida Statutes, application is hereby submitted to form and operate a Health Maintenance Organization.

Proposed name of Health Maintenance 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: _____

This company, through its duly authorized officers, hereby applies for a certificate of authority authorizing and empowering it to operate as a Health Maintenance 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.

APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION

APPLICATION CERTIFICATION

The undersigned states that they are an officer having personal knowledge of the application submitted to the Florida Office of Insurance Regulation in connection with the intention of _____ ("Applicant") to acquire a Florida insurer, either directly, indirectly, or via merger; that they have read all of the responses, information, exhibits, and documents submitted with, and in support of, this application; and that the submissions are true, correct, and complete to the best of their knowledge. The undersigned further represent that they have the authority to bind the Applicant, and that by their signatures on the instrument, the Applicant has executed the instrument.

The undersigned understand that whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his or her official duties is guilty of a misdemeanor of the second degree, pursuant to Section 837.06, Florida Statutes, punishable as provided in Section 775.082 or Section 775.083, Florida Statutes.

(Corporate Seal)

By: _____

Print Name: _____

Title: _____

Date: _____

STATE OF _____

COUNTY OF _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence

or ☐ online notarization, this ____ day of _____ 20__, by_____
(name of person) as

_____ for _____.
(type of authority; e.g., officer, trustee, attorney in fact) (company name)

_____
(Signature of the Notary)

_____
(Print, Type or Stamp Commissioned Name of Notary)

Personally Known _____ OR Produced Identification_____

Type of Identification Produced_____

My Commission Expires: _____

OIR-C1-942
REV 5/22
69O-191.027

APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION

INVOICE

NAME OF HEALTH MAINTENANCE 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 check and invoice only to the Florida Department of Financial Services, Revenue Processing Section, P.O. Box 6100, Tallahassee, Florida 32314-6100.

2. Include a copy of the check and invoice with the application filing submitted electronically via iApply.

For Accounting Use Only

==========

B/T	TY/CL	F/T	AMOUNT
C	12/47	F	$1,000

Department of Financial Services
Office of Insurance Regulation

APPLICATION FOR CERTIFICATE OF AUTHORITY HEALTH MAINTENANCE ORGANIZATION

REHABILITATION ADMINISTRATIVE EXPENSE FUND (Pursuant to Section 641.227, F.S.)

NAME OF HEALTH MAINTENANCE ORGANIZATION: _____

_____

FEIN: _____

ADDRESS: _____

CITY, STATE & ZIP CODE: _____

PHONE NUMBER: _____

In reference to the submission of the above-referenced Health Maintenance Organization's Application for Certificate of Authority to do business in Florida, it is necessary for this form to be returned to the address below with proper payment.

PLEASE NOTE:

1. **Send a check in the amount indicated, made payable to the Department of Financial Services, and mail the check and invoice to the 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, Application Coordination Section, 200 East Gaines Street, Larson Building, Tallahassee, Florida 32399-0332.**

For Accounting Use Only

==========

B/T	TY/CL	F/T	AMOUNT
C	12/00	A	$10,000

OIR-C1-1263
REV 6/96
69O-191.027

OFFICE OF INSURANCE REGULATION
Bureau of Life & Health Forms and Rates

SMALL EMPLOYER CARRIER'S APPLICATION TO BECOME A RISK ASSUMING CARRIER OR A REINSURING CARRIER, AS REQUIRED BY SECTION 627.6699(9), FLORIDA STATUTES

CARRIER NAME _____

ADDRESS (CITYSTZIP) _____

_____

FEIN: _____ NAIC GROUP CODE: _____ NAIC COMPANY CODE: _____

As required under the provisions of Section 627.6699(11), Florida Statutes, we hereby apply to elect the following status. (Select one block only.)

☐ **A. Reinsuring Carrier**

A reinsuring carrier, as the term is used in Section 627.6699, Florida Statutes, is a direct writer of small employer health benefit plans and participates in the small employer health reinsurance program created by Section 627.6699 (11). If reinsuring carrier status is elected, nothing further is required except completion of the signature line on page 2 and submission to the Office.

☐ **B. Risk Assuming Carrier**

If risk-assuming carrier status is elected, attach information showing that the carrier is financially capable of assuming that status pursuant to the criteria in items 1 through 4, below; then complete the signature line at the bottom of the page and send to the Office, Bureau of Life and Health Forms and Rates.

1. The carrier's financial ability to support the assumption of risk of small employer groups. The carrier shall demonstrate that its surplus is adequate to support the fair marketing required by the act and that the planned premium volume after becoming a risk-assuming carrier does not endanger the financial condition of the carrier or endanger the interest ofthe carrier's policyholder.

2. The carrier's history of rating and underwriting small employers groups. The carrier shall demonstrate that it has successfully engaged in the business of transacting rating and underwriting of small employer groups or is the wholly owned subsidiary of such a company and that its condition and methods of operation in connection with small employer group contracts will not be such as to render its operation hazardous to the public or its policyholders in this state.

3. The carrier's commitment to market fairly to all small employers in the state or its service area, as applicable. The carrier shall include a statement that the applicant has read and will comply with Section 627.6699 (13), Florida Statutes, Standards to Assure Fair Marketing. The Office shall consider the character, responsibility and general fitness of the officers and directors and the past market conduct of the carrier or its representatives.

4. The carrier's ability to assume and manage the risk of enrolling without the protection of the reinsurance program provided by Section 627.6699 (11), Florida Statutes. The Office shall consider the history and financial condition of the company. It should be demonstrated that the financial condition of the carrier is adequate to assume the risk of marketing or their employees' health status to comply with the purpose and intent of the law as stated in Section 627.6699 (2) without the benefit of the special reinsurance program created by Section 627.6699 (11) for reinsuring carriers. If part of the response is that your existing reinsurance program will be depended upon to cover such risks that you may be required to assume, include a copy of the reinsurance treaty with a summary of how it applies to these risks. The requirement of a copy of the reinsurance treaty does not apply to carriers that have a policyholder surplus in excess of $100,000,000.

☐ **C. Not Applicable:** The carrier will not issue health benefit plans or products to Florida small employer groups as defined in Section 627.6699, Florida Statutes.

_____ _____
Signature of Officer Date

_____ _____
Name of Officer Position or Title

PLEASE TYPE OR PRINT DATE, POSITION OR TITLE, AND NAME OF OFFICER

Form OIR-B2-1093 to be submitted as follows:

Office of Insurance Regulation
Bureau of Life & Health Forms and Rates
Larson Building
Tallahassee, FL 32399-0328

Florida Office of Insurance Regulation

Management Information Form

Provide a complete listing of the individuals or entities managing, owning, or exercising control over the entity named below, i.e., Incorporators, Officers, Directors, 10% or Greater Shareholders, Partners, Proprietors, Management Company Principals, Association Members, Trustees, Key Individuals, and other like positions (5% if an HMO). Please type or print clearly.

Name of Entity: _____

Name	Title (e.g.: President)	Position (e.g.: Officer)	Ownership %

*Additional pages in like format may be attached as necessary

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. The background investigative report must be conducted using the same affidavit submitted to the Florida Office of Insurance Regulation ("Office") for each individual as part of the application.

2. For specific information regarding background investigation vendors, please refer to the NAIC website, "Third Party Vendors for Background Reports" at: http://www.naic.org/industry_ucaa.htm

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 submit investigative reports electronically to the Office to this e-mail address:

bkgrnd-inv@floir.com

Submissions should be 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. Questions regarding this process may be directed to pcappcoord@floir.com (Property and Casualty applicants) or to lhappcoord@floir.com (Life and Health applicants).

FINGERPRINT PAYMENT AND SUBMISSION PROCEDURE

Each individual subject to the fingerprinting process must be registered through IdentoGO by Idemia, at https://fl.ibtfingerprint.com/**.** For payment, processing, or appointment issues please contact the IdentoGo Customer Service Center at 1-800-528-1358.

DIGITAL PRINTS - Florida Residents only:

Access https://fl.ibtfingerprint.com/**,** select "Schedule a New Appointment" and follow the prompts. Please retain a copy of the payment confirmation as it will be a required component in the electronic application submitted via iApply.

FINGERPRINT CARD – Non-Florida Residents (and Florida residents who are physically unable to be digitally fingerprinted):

Access https://fl.ibtfingerprint.com/**, s**elect "Register for Fingerprint Card Processing Service" and follow the prompts. Select "No Cards" on the Shipping Details screen. Retain a copy of the payment confirmation as it will be a required component in the electronic application submitted via iApply.

Everyone must complete **two** fingerprint cards provided by the Florida Office of Insurance Regulation. Blank fingerprint cards may be requested by emailing FPRequest@floir.com. Fingerprinting must be performed by a technician within a law enforcement agency or other authorized entity. Most law enforcement agencies and many security companies provide civil applicant fingerprinting services.

NOTE: Please print your Payment Confirmation Number from the IdentoGo website on the "REF" line of the fingerprint card. Not including your Payment Confirmation Number will result in a delay of processing your submission.

Mail ONLY completed cards with a cover letter to:

Florida Office of Insurance Regulation
Market Research & Technology Unit
Fingerprint Card Processing
Room B-50 Larson Building
200 East Gaines Street
Tallahassee, Florida 32399-0326

Do NOT mail application paperwork with your fingerprint cards. All application materials must be sent directly to the appropriate unit (Property & Casualty Company Admissions or Life & Health Company Admissions) within the Office of Insurance Regulation. Failure to do so will result in a delay to your application.

OIR-C1-938
Rev: 9/21
69O-144.002

CONFIDENTIAL

Pursuant to section 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. 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 ensure 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 the 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

FDLE NOTICE FOR APPLICANTS SUBMITTING FINGERPRINTS FOR A CRIMINAL HISTORY RECORD CHECK

NOTICE OF:

- RETENTION OF FINGERPRINTS,
- PRIVACY POLICY, AND
- RIGHT TO CHALLENGE AN INCORRECT CRIMINAL HISTORY RECORD

This notice is to inform you when you submit a set of fingerprints to the Florida Department of Law Enforcement (FDLE) for the purpose of conducting a search for any Florida and national criminal history records that may pertain to you, the results of the search are returned to the authorized agency ORI indicated in the transaction. By submitting fingerprints, you are authorizing the dissemination of any state and national criminal history record that may pertain to you to the agency from which you are seeking approval to be employed, licensed, or have access to their facility. The fingerprints submitted are retained by FDLE and the Federal Bureau of Investigation (FBI), and FDLE will notify the agency of any subsequent arrests.

Your Social Security Account Number (SSAN) is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 U.S.C. § 552a), FDLE is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. FDLE does not require a SSAN but it could cause a delay in processing your criminal history record check.

Authorized agencies are allowed to release a copy of the state and national criminal record information to a person who requests a copy of his or her own record if the identification of the record was based on submission of the person's fingerprints. Therefore, if you wish to review your record, you may request a copy of your record from the screening agency. After you have reviewed the criminal history record, if you believe it is incomplete or inaccurate, you may conduct a personal review as provided in s. 943.056, F.S., and Rule 11C-8.001, F.A.C. by calling FDLE at (850) 410-7898. If you believe the national information is in error, you may contact the FBI at (304) 625-2000. You can receive any national criminal history record that may pertain to you directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34. You have the right to obtain a determination as to the validity of your challenge before a final decision is made about your status as an employee, volunteer, contractor, or subcontractor within a reasonable time.

The FBI's Privacy Statement follows on a separate page and contains additional information.

PRIVACY ACT STATEMENT

Authority: The FBI's acquisition, preservation, and exchange of fingerprints and associated information is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal rules providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.

Social Security Account Number (SSAN). Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal agencies to use this number to help identify individuals in agency records.

Principal Purpose: Certain determinations, such as employment, licensing, and security clearances, may be predicated on fingerprint-based record checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.

Routine Uses: During the processing of this application and for as long thereafter as your fingerprints and associated information/biometrics are retained in NGI, your information may be disclosed pursuant to your consent, and may be disclosed without your consent as permitted by the Privacy Act of 1974 and all applicable Routine Uses as may be published at any time in the Federal Register, including the Routine Uses for the NGI system and the FBI's Blanket Routine Uses. Routine uses include, but are not limited to, disclosures to: employing, governmental or authorized non-governmental agencies responsible for employment, contracting licensing, security clearances, and other suitability determinations; local, state, tribal, or federal law enforcement agencies; criminal justice agencies; and agencies responsible for national security or public safety.

Additional Information: The requesting agency and/or the agency conducting the application- investigation will provide you additional information pertinent to the specific circumstances of this application, which may include identification of other authorities, purposes, uses, and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch that has published notice in the Federal Register describing any systems(s) of records in which that agency may also maintain your records, including the authorities, purposes, and routine uses for the system(s).

Applicant Company Name: <Enter the Applicant Company Name for a Single Company>
NAIC No.:_____ FEIN: _____

Uniform Certificate of Authority Application (UCAA)
BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Specify Purpose for Completion:

Form A: <See UCAA FAQs for details> **UCAA Type:** _<See UCAA FAQs for details> **Other:** <See UCAA FAQs for details>

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).

Applicant Company Name: <Enter the Applicant Company Name for a Single Company>
Address: <Enter Applicant Company Address> City: <Enter Applicant Company City>
State/Province: <Enter Applicant Company State/Province> Postal Code: <Enter App. Co. Zip/Postal Code> Phone: <Enter App. Co. Phone>

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. ALL FIELDS MUST HAVE A RESPONSE. INCOMPLETE FORMS COULD DELAY THE APPLICATION PROCESS or RESULT IN REJECTION OF THE APPLICATION.

1. Affiant's Full Name (Initials Not Acceptable): First:_____ Middle:_____ Last:_____

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

   Yes ☐ No ☐

   b. Are you a citizen of any other country?

   Yes ☐ No ☐

   If yes, what country? _____

3. Affiant's occupation or profession:_____

4. Affiant's business address:_____

   Business telephone:_____ Business Email: _____

5. Education and training:

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

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

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

Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

Applicant Company Name: <Enter the Applicant Company Name for a Single Company>
NAIC No.:______________________________FEIN: ______________________

6. List of memberships in professional societies and associations:

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

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

____

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

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: <Enter the Applicant Company Name for a Single Company>
NAIC No.: _____ FEIN: _____

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

Yes ☐ No ☐

If any claims were made on the bond, give details: _____

_____

_____

_____

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?

Yes ☐ No ☐

If yes, give details: _____

_____

_____

_____

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

Organization/Issuer of License: _____ Address: _____

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

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

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

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

Organization/Issuer of License: _____ Address: _____

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

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

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

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

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

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

Yes ☐ No ☐

b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?

Yes ☐ No ☐

c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?

Yes ☐ No ☐

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

Yes ☐ No ☐

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

Yes ☐ No ☐

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?

Yes ☐ No ☐

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?

Yes ☐ No ☐

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

Yes ☐ No ☐

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?

Yes ☐ No ☐

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

Yes ☐ No ☐

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

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.

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

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

Yes ☐ No ☐

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

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

14. Have you ever been adjudged a bankrupt?

Yes ☐ No ☐

If yes, provide details:

15. To your knowledge has any company or entity (including entities controlled by the holding company) for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity? If employed at the holding company level provide the group code. _____

Applicant Company Name: <Enter the Applicant Company Name for a Single Company>
NAIC No.:_____ FEIN: _____

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 ☐

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.

____I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

_____
(Signature of Affiant)

State of:_____County of: _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, 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: <Enter the Applicant Company Name for a Single Company>
NAIC No.:_____ FEIN: _____

BIOGRAPHICAL AFFIDAVIT
Supplemental Personal Information

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Specify Purpose for Completion:

Form A: <See UCAA FAQs for details> **UCAA Type:** <See UCAA FAQs for details> **Other:** <See UCAA FAQs for details>

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).

Applicant Company Name: <Enter the Applicant Company Name for a Single Company>

Address: <Enter Applicant Company Address> City: <Enter Applicant Company City>

State/Province: <Enter Applicant Company State/Province> Postal Code: <Enter App. Co. Phone: <Enter App. Co.

1. Affiant's Full Name (Initials Not Acceptable): First:_____ Middle:_____ Last:_____

IF ANSWER IS "NO" OR "NONE," SO STATE. ALL FIELDS MUST HAVE A RESPONSE. INCOMPLETE FORMS COULD DELAY THE APPLICATION PROCESS or RESULT IN REJECTION OF THE APPLICATION.

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

Yes ☐ No ☐

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

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

Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. Affiant's Social Security Number: _____

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

Government ID Number:	Country of Issuance:

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

Applicant Company Name: <Enter the Applicant Company Name for a Single Company>
NAIC No.: _____ FEIN: _____

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

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

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

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

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

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

___ I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

_____
(Signature of Affiant)

State of: _____ County of: _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, 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: <Enter the Applicant Company Name for a Single Company>
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) six (6) 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 by means of ☐ physical presence or ☐ online notarization, 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: <Enter the Applicant Company Name for a Single Company>
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) six (6) 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 by means of ☐ physical presence or ☐ online notarization, 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: <Enter the Applicant Company Name for a Single Company>
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 six (6) 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 by means of ☐ physical presence or ☐ online notarization, 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: <Enter the Applicant Company Name for a Single Company>
NAIC No.: FEIN:

Addendum pages are used for additional responses carried over from the biographical affidavit questions. Responses must be labeled and signed by the affiant. Attachments included as addendum's must also be signed by the affiant. Refer to the FAQ's on the UCAA webpage for additional questions.

Applicant Company Name: <Enter the Applicant Company Name for a Single Company>
NAIC No.:_____ FEIN: _____

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