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

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

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