Office of Insurance Regulation
Company Admissions

APPLICATION FOR LIFE EXPECTANCY PROVIDER

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.

If this package requires original documents, in lieu of providing original paper documents, the Applicant is directed to submit a PDF of the original document(s) unless otherwise required by Florida Statutes.

Any questions concerning this application package or iApply may be directed to lhappcoord@floir.com

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

APPLICATION FOR REGISTRATION
LIFE EXPECTANCY PROVIDER INSTRUCTIONS

SECTION I - APPLICATION FEE AND FORM

Section I-1 Application Fee

The application filing fee is $500.00. Secure the check to the invoice, which is included in this package, and send to:

Florida Department of Financial Services
Revenue Processing Section
P.O. 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 Application for Registration to Conduct Business in the State of Florida - Life Expectancy Provider

The application must be under oath and signed by the applicant. If the applicant is a corporation, an original signature under oath by the applicant's president and secretary must appear on this form or their equivalents if another type of entity.

Pursuant to Rule 69O-204.201(2), Florida Administrative Code, "Person performing life expectancies" as used in s. 626.99175(4)(d), Florida Statutes, and "individuals who determine life expectancies" as used in s. 626.99175(4)(g)2, Florida Statutes, means a person or individual with the decision making authority to sign or authorize the issuance of a life expectancy or mortality ratings used to determine a life expectancy.

APPLICATION FOR REGISTRATION
LIFE EXPECTANCY PROVIDER INSTRUCTIONS

SECTION II - LEGAL

Section II-1 Letter of Authorization

Provide a letter of authorization designating the named individual, other than company personnel, to represent the applicant, if applicable.

Section II-2 Organizational Documents

Submit a certified copy of the applicant's organizational documents, if any, including the articles of incorporation, articles of association, partnership agreement, trust agreement, or other similar documents, together with all amendments to such documents.

Section II-3 Certificate of Status from State of Domicile

Submit a certificate of status. A certificate of status is a document issued by the applicant's state of domicile public records custodian for corporate records, generally the Secretary of State. The certificate documents that the applicant is duly organized and that all state taxes and fees have been paid. The certificate must show good standing, be sealed by the state, and be a recently prepared original document.

Section II-4 Bylaws, Rules, Regulations, or Similar Documents

Submit copies of all of the applicant's bylaws, rules, regulations, or similar documents regulating the conduct of the applicant's internal affairs. Corporate bylaws must be recently sealed, signed, and dated by the Secretary of the applicant or their equivalents if another type of entity.

Section II-5 Certificate of Status from Florida Secretary of State

Foreign corporations are required to secure through the Florida Secretary of State, a charter to do business in Florida. If you have any questions concerning filing with the Florida Secretary of State, please contact their Division of Corporations at (850) 245-6053. The Secretary of State will mail you a certificate of status. This original certificate must be forwarded to the Office of Insurance Regulation as part of your life expectancy provider application as proof of your filing with the Secretary of State as a foreign corporation.

Section II-6 Fictitious Name Filing

If the applicant plans to utilize a fictitious name, provide documentation of compliance with the fictitious name statutes of this state. Contact the Florida Secretary of State at (850) 245-6059 for assistance in complying with this requirement.

APPLICATION FOR REGISTRATION
LIFE EXPECTANCY PROVIDER INSTRUCTIONS

SECTION III – BUSINESS PLAN OF OPERATIONS

Section III-1 Business Plan of Operations

Please provide a narrative of the applicant's business plan of operations including, but not limited to, the following information and documentation:

A. History

1. A brief history of the applicant, to include, full name (present or prior, legal or fictitious names), age, residence address, and business address and all occupations engaged by the applicant during the 5 years preceding the date of the application.

2. Complete information concerning any criminal, civil or administrative actions pending or final against the applicant and any litigation brought in connection with the business of the issuance of life expectancies used in connection with a viatical settlement contract or viatical settlement investment, or any other administrative, civil or criminal action in which the applicant has been named as a defendant or co-defendant.

3. Statement as to whether or not a viatical settlement broker, viatical settlement provider or insurance agent in the business of viatical settlements in this state, directly or indirectly, owns or is an officer, director, or employee of the applicant or a life expectancy provider.

B. Organizational Chart

A schematic external organizational chart disclosing the applicant's relationship with any other entities, including the ultimate controlling company or controlling person. Label all appropriate ownership percentages.

C. Business Operations

1. A general description of the policies and procedures covering all life expectancy determination criteria and protocols:

   i. A general description of the plan or plans of policies and procedures used to determine life expectancies.
   ii. A general description of how the applicant updates its manuals, underwriting guides, mortality tables, and other reference works and ensures that the applicant bases its determination of life expectancies on current data.

SECTION III – BUSINESS PLAN OF OPERATIONS – cont'd

2. The applicant's plan for assuring confidentiality of personal, medical, and financial information in accordance with federal and state laws.

3. i. A list of persons performing life expectancies and a description of their experience.

   ii. A general description of the training, including continuing training of the individuals who determine life expectancies.

D. Provide any other information the applicant deems pertinent to its application that will assist the Office in determining if the applicant has met the minimum statutory requirements for registration.

Section III-2 Anti-Fraud Plan

Provide two copies of the anti-fraud plan required by Section 626.99278, Florida Statutes. One copy to be forwarded to the Division of Fraud and the other retained to support your application.

Section III-3 Addresses and Location of Books and Records

Provide the following addresses and corresponding telephone and facsimile numbers, where applicable:

A. Home office;
B. Administrative office;
C. Mailing;
D. Florida office;
E. Location of records pertaining to life expectancy business of the applicant; and
F. Location of any storage facility where books or records pertaining to the life expectancy business of the applicant are or will be stored.

APPLICATION FOR REGISTRATION
LIFE EXPECTANCY PROVIDER INSTRUCTIONS

SECTION IV - MANAGEMENT

ANY NAMES REQUESTED IN THIS SECTION SHOULD INCLUDE COMPLETE FIRST, MIDDLE AND LAST NAME. PLEASE STATE IF A MIDDLE NAME DOES NOT EXIST.

Section IV-1 List of all Officers, Directors, Stockholders, Other Persons and Person(s) Performing Life Expectancies.

Complete the Management Information Form, to include, the name, business and residence address, and official position of each individual who is responsible for the conduct of the applicant's affairs, including, but not limited to, any member of the board of directors, board of trustees, executive committee, or other governing board or committee and any other person or entity owning or having the right to acquire 10 percent or more of the voting securities of the applicant and any person performing life expectancies.

Include officers and directors up through the ultimate parent corporation or holding company; or person(s) occupying similar positions if other than a corporation and all persons who exercise or have the ability to exercise effective control of the applicant. Use a separate form for each company.

Section IV-2 Biographical Affidavit

Complete and provide a Biographical Affidavit for each person listed in Section IV-1 except for those companies in the organizational structure between the immediate parent and the ultimate parent. Additionally, each individual will need to submit:

1. A statement as to whether or not they have been associated with any other life expectancy provider or have performed any services for a person in the business of viatical settlements and provide details, if applicable; and

2. A sworn statement of any criminal, civil or administrative actions pending or final against the individual.

If, however, the Biographical Affidavits are currently on file and are not more than two years old, no submission is necessary.

APPLICATION FOR REGISTRATION
LIFE EXPECTANCY PROVIDER INSTRUCTIONS

SECTION IV – MANAGEMENT – cont'd

The requirement 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 Social Security Number on Page 6 of the Biographical Affidavit form, include the affiant's name and social security number 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 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, to any felony or crime punishable by imprisonment of one year.

APPLICATION FOR REGISTRATION
LIFE EXPECTANCY PROVIDER INSTRUCTIONS

AGREEMENTS & AUDIT OF LIFE EXPECTANCIES

SECTION V – AGREEMENTS, CONTRACTS OR OTHER ARRANGEMENTS

Provide a list of any agreements, contracts, or any other arrangement to provide life expectancies to a viatical settlement provider, viatical settlement broker, or any other person in the business of viatical settlements in connection with any viatical settlement contract or viatical settlement investment.

SECTION VI – AUDIT OF LIFE EXPECTANCIES

As part of the application, the applicant is required to file with the Office an audit of all life expectancies by the applicant for the 5 calendar years immediately preceding such audit, which audit shall be conducted and certified by a nationally recognized actuarial firm and shall include the following information:

A. A mortality table;

B. The number, percentage, and an actual-to-expected ratio of life expectancies in the following categories:

1. Life expectancies of less than 24 months
2. Life expectancies of 25 to 48 months
3. Life expectancies of 49 to 72 months
4. Life expectancies of 73 to 108 months
5. Life expectancies of 109 to 144 months
6. Life expectancies of 145 to 180 months
7. Life expectancies of more than 180 months

The audit of life expectancies must comply with the requirements of Section 626.99175(5), Florida Statutes and Rule 69O-204.201(3), Florida Administrative Code.

APPLICATION FOR REGISTRATION
LIFE EXPECTANCY PROVIDER CHECKLIST

SECTION I - APPLICATION FEE AND FORM

Applicant Name: _____

Item #			Completion Check List
1.	Life Expectancy Provider application fee paid		☐
	a.	Copy of invoice included	☐
	b.	Copy of check included	☐
	c.	Original invoice (Official Form) and check mailed to Bureau of Financial Services	☐
2.	Applicant completed application for registration (Official Form)		☐
	a.	All blanks completed	☐
	b.	Sealed by company (as applicable).....	☐
	c.	Signed by president and secretary (original signatures)	☐
	d.	Notarized (Original signatures)	☐

RETURN THE COMPLETED CHECK LIST WITH THE APPLICATION PACKAGE.

APPLICATION FOR REGISTRATION
LIFE EXPECTANCY PROVIDER CHECKLIST

SECTION II - LEGAL

Applicant Name: _____

Item #			Completion Check List
1.	Letter of Authorization (if applicable)		☐
2.	Organizational Documents (original certification and all amendments)		
	a.	Articles of Incorporation	☐
	b.	Articles of Association	☐
	c.	Partnership Agreement	☐
	d.	Trust Agreement	☐
	e.	Other	☐
3.	Certificate of Status from State of Domicile		☐
	a.	Good standing indicated	☐
	b.	Sealed by state	☐
	c.	Signed by proper public official	☐
	d.	Original	☐
4.	Bylaws, Rules, Regulations or Similar Documents		☐
	a.	Signed and dated by corporate secretary (or equivalent).....	☐
	b.	Corporate seal (as applicable)	☐
5.	Original Certificate of Status from Florida Secretary of State (Foreign Corporations).....		☐
6.	Original Fictitious Name Certificate (if applicable)		☐

RETURN THE COMPLETED CHECK LIST WITH THE APPLICATION PACKAGE.

APPLICATION FOR REGISTRATION
LIFE EXPECTANCY PROVIDER CHECKLIST

SECTION III – BUSINESS PLAN OF OPERATIONS

Applicant Name: _____

Item #			Completion Check List
1.	Business Plan of Operations		☐
	A.	History	☐
		(1) Brief history of the applicant	☐
		(2) Information regarding criminal, civil or administrative actions pending or final against the applicant…..	☐
		(3) Statement whether viatical settlement broker, viatical settlement provider or insurance agent is an owner, officer, director or employee of applicant.....	☐
	B.	Organizational Chart.....	☐
	C.	Business Operations.....	☐
		(1) General description of the following policies and procedures covering all life expectancy determination criteria and protocols:	
		(i) Plans and procedures used to determine life expectancies	☐
		(ii) Updating procedures for manuals, underwriting guides, mortality tables and other referenced works.....	☐
		(2) Plan for assuring confidentiality of personal, medical and financial information….....	☐
		(3)(i) List of individuals performing life expectancies and description of experience.....	☐
		(ii) Training of individuals who determine life expectancies.....	☐

APPLICATION FOR REGISTRATION
LIFE EXPECTANCY PROVIDER CHECKLIST

SECTION III – BUSINESS PLAN OF OPERATIONS– Cont'd

Applicant Name: _____

Item #			Completion Check List
	D.	Additional information	☐
2.		Two copies of the anti-fraud plan required by Section 626.99278, F.S.....	☐
3.		Addresses and location of books and records**.** Provide the following addresses and corresponding telephone and facsimile numbers, where applicable:	
	A.	Home office.....	☐
	B.	Administrative office	☐
	C.	Mailing.....	☐
	D.	Florida office.....	☐
	E.	Location of records pertaining to life expectancy business	☐
	F.	Location of any storage facility where records pertaining to the life expectancy business of the applicant are or will be stored…….....	☐

RETURN THE COMPLETED CHECK LIST WITH THE APPLICATION PACKAGE.

APPLICATION FOR REGISTRATION
LIFE EXPECTANCY PROVIDER CHECKLIST

SECTION IV - MANAGEMENT

Applicant Name: _____

Item #		Completion Check List
1.	List of all Officers, Directors, Stockholders, Other Persons and Person(s) Performing Life Expectancies	
	Management Information Form (Official Form).....	☐
2.	Biographical Affidavit	☐
	Biographical Affidavit for each applicable individual (Official Form)	☐
	(i) All blanks completed.....	☐
	(ii) Contains original signature.....	☐
	(iii) Notarized (original)	☐
	(iv) Full name given (including full middle name or indication if one does not exist).....	☐
	1. Statement of association with other life expectancy providers or others in the business of viatical settlements.....	☐
	2. Sworn statement of any criminal, civil or administrative actions pending or final.....	☐

RETURN THE COMPLETED CHECK LIST WITH THE APPLICATION PACKAGE.

APPLICATION FOR REGISTRATION
LIFE EXPECTANCY PROVIDER CHECKLIST

SECTION V – AGREEMENTS, CONTRACTS OR OTHER ARRANGEMENTS

Applicant Name: _____

Item #		Completion Check List
1.	List of any agreements, contracts or other arrangement to provide life expectancies in connection with any viatical settlement contract or viatical settlement investment	☐

SECTION VI – AUDIT OF LIFE EXPECTANCIES

1.	Audit of Life Expectancies conducted and certified by a nationally recognized actuarial firm	☐
	A. Mortality table	☐
	B. The number, percentage, and an actual-to-expected ratio of life expectancies in the following categories:	
	(i) Life expectancies of less than 24 months….....	☐
	(ii) Life expectancies of 25 to 48 months.....…...	☐
	(iii) Life expectancies of 49 to 72 months.....	☐
	(iv) Life expectancies of 73 to 108 months.....	☐
	(v) Life expectancies of 109 to 144 months.....	☐
	(vi) Life expectancies of 145 to 180 months.....	☐
	(vii) Life expectancies of more than 180 months.....	☐
	C. Audit of Life Expectancies in compliance with Section 626.99175(5), F.S. and Rule 69O-204.201(3), Florida Administrative Code	☐

RETURN THE COMPLETED CHECK LIST WITH THE APPLICATION PACKAGE.

INVOICE
LIFE EXPECTANCY PROVIDER
PAYMENT OF APPLICATION FEE

NAME OF APPLICANT: _____

FEIN#: _____

ADDRESS: _____

CITY, STATE & ZIP CODE: _____

ADDRESS (IF DIFFERENT FROM APPLICANT ADDRESS)

_____

_____ _

(CITY) (STATE) (ZIP CODE)

TELEPHONE NUMBER: _____

It is necessary for you to return this form with the fee payment.

PLEASE NOTE:

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.

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

RECEIPT NUMBER	F/T	AMOUNT	TYPE	CLASS B/T
	F	$500.00	10	37

OFFICE OF INSURANCE REGULATION
APPLICATION FOR REGISTRATION
TO CONDUCT BUSINESS IN THE STATE OF FLORIDA
LIFE EXPECTANCY PROVIDER

DATE _____

TO THE COMMISSIONER OF INSURANCE REGULATION, TALLAHASSEE, FLORIDA

_____
(Full Legal Name of Applicant)

FEIN: _____

of _____ _____ _____ _____ (Business Address) (City) (State) (Zip)

Telephone: ( ) – Facsimile: ( ) –

of _____ _____ _____ _____ (Residence Address) (City) (State) (Zip)

Through its duly authorized officers, hereby applies for registration authorizing and empowering the aforesaid to act as a life expectancy provider in the State of Florida, under the laws thereof, and do after being duly sworn 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.

STATE OF _____
COUNTY OF _____

The foregoing instrument was acknowledged before me this _____ day of _____ 20 _____

by _____ as _____
(Name of person) (Type of authority..... e.g. officer, trustee attorney in fact)

for _____
(Company Name)

_____
(Signature of the Notary)

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

Personally Known ☐ OR Produced Identification ☐
Type of Identification Produced:

Name and title of person filing this application: _____
Company: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Telephone: ( ) – Facsimile: ( ) –
E-Mail Address: _____

UNIFORM CERTIFICATE OF AUTHORITY APPLICATION (UCAA)
Management Information Form
Complete Listing of Incorporators*, Officers
Directors and Shareholders (10% or more)

Incorporators*	Titles:	Ownership Percentage:

Officers:

Directors:

Shareholders:

* Primary Application Only

Applicant Company Name: Applicant Company Name
NAIC No.:NAIC No. FEIN: 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: Form A **UCAA Type:** UCAA Type **Other:** Other

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: Applicant Company Name

Address: Applicant Company Address City: Applicant Company City

State/Province: State/Province Postal Code: Postal Code Phone: 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: First Name Middle: Middle Name Last: Last Name

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? If yes, what country?

3. Affiant's occupation or profession: Affiant's occupation or profession

4. Affiant's business address: Affiant's business address

Business telephone: Business telephone Business email: Business email

5. Education and training:

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

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

Other Training: Name	City/State	Dates Attended (MM/YY)	Degree/Certification Obtained
Other Training: Name (OT)	OT City/State	MM/YY-MM/YY	OT 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: Applicant Company Name
NAIC No.:NAIC No. FEIN: 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
Name of Soc./Assoc.	Contact Name	Address of Soc./Assoc.	Telephone No. of Soc./Assoc.
Name of Soc./Assoc.	Contact Name	Address of Soc./Assoc.	Telephone No. of Soc./Assoc.
Name of Soc./Assoc.	Contact Name	Address of Soc./Assoc.	Telephone No. of Soc./Assoc.

7. Present or proposed position with the Applicant Company: 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): MM/YY- MM/YY Employer's Name: Employer's Name.

Address: Address City: City State/Province: State/Province

Country: Country Postal Code: Postal Code Phone: Phone Offices/Positions Held: Office/Position

Type of Business: Type of Business Supervisor/Contact: Supervisor/Contact

Beginning/Ending
Dates (MM/YY): MM/YY- MM/YY Employer's Name: Employer's Name.

Address: Address City: City State/Province: State/Province

Country: Country Postal Code: Postal Code Phone: Phone Offices/Positions Held: Office/Position

Type of Business: Type of Business Supervisor/Contact: Supervisor/Contact

Beginning/Ending
Dates (MM/YY): MM/YY- MM/YY Employer's Name: Employer's Name.

Address: Address City: City State/Province: State/Province

Country: Country Postal Code: Postal Code Phone: Phone Offices/Positions Held: Office/Position

Type of Business: Type of Business Supervisor/Contact: Supervisor/Contact

Beginning/Ending
Dates (MM/YY): MM/YY- MM/YY Employer's Name: Employer's Name.

Address: Address City: City State/Province: State/Province

Country: Country Postal Code: Postal Code Phone: Phone Offices/Positions Held: Office/Position

Type of Business: Type of Business Supervisor/Contact: Supervisor/Contact

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: 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: 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.

Question 10, Give Details

Organization/Issuer of License: Org/Issuer License Address: Address

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

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

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

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

Organization/Issuer of License: Org/Issuer License Address: Address

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

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

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

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

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.

If yes, provide details including dates, locations, dispositions, etc.

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

List any entity subject to regulation by an insurance regulatory authority that control directly or indirectly.

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

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.

    Provide Details.

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

    If shares are pledged or hypothecated, give details.

14. Have you ever been adjudged a bankrupt?

    ☐ Yes ☐ No

    If yes, provide details: 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. Group Code(s).

    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.

    If the answer to any of the above is yes, please indicate and give details.

    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.

Applicant Company Name: Applicant Company Name
NAIC No.:NAIC No. FEIN: FEIN

Dated and signed this Day day of Month 20Year at Click or tap here to enter text.. 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: State of. County of: County of.

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐online notarization, this Day day of Month, 20Year by By., and: ☐ who is personally known to me, or ☐ who produced the following identification: Produced the following identification..

[SEAL]

_____
Notary Public

_____
Printed Notary Name

_____
My Commission Expires

Applicant Company Name: Applicant Company Name
NAIC No.:NAIC No. FEIN: 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. 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: Form A **UCAA Type:** UCAA Type **Other:** Other

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: Applicant Company Name

Address: Applicant Company Address City: Applicant Company City

State/Province: State/Province Postal Code: Postal Code Phone: Phone

1. Affiant's Full Name (Initials Not Acceptable): First: First Name Middle: Middle Name Last: Last Name
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)
MM/YY – MM/YY.	Name(s) and Specify	Reason.
MM/YY – MM/YY.	Name(s) and Specify	Reason.
MM/YY – MM/YY.	Name(s) and Specify	Reason.

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: XXX-XX-XXXX.

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

Government ID Number:	Country of Issuance:
Govt. ID Number	Country of Issuance
Govt. ID Number	Country of Issuance
Govt. ID Number	Country of Issuance

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

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

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

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
MM/YY – MM/YY.	Address	City	State/Province	Country	Postal Code
MM/YY – MM/YY.	Address	City	State/Province	Country	Postal Code
MM/YY – MM/YY.	Address	City	State/Province	Country	Postal Code
MM/YY – MM/YY.	Address	City	State/Province	Country	Postal Code
MM/YY – 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 day of Month, 20Year at Click or tap here to enter text.. 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: State of. County of: County of.

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐online notarization, this Day day of Month, 20Year by By., and: ☐ who is personally known to me, or ☐ who produced the following identification: Produced the following identification..

[SEAL]

_____
Notary Public

_____
Printed Notary Name

_____
My Commission Expires

Applicant Company Name: Applicant Company Name
NAIC No.:NAIC No. FEIN: 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 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. **[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.
(Printed Full Name and Residence Address)

_____ _____
(Signature) (Date)

State of: State of. County of: County of.

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐online notarization, this Day day of Month, 20Year by By., and: ☐who is personally known to me, or ☐ who produced the following identification: Produced the following identification..

[SEAL]

_____
Notary Public

_____
Printed Notary Name

_____
My Commission Expires

Applicant Company Name: Applicant Company Name
NAIC No.:NAIC No. FEIN: 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 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. **[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.
(Printed Full Name and Residence Address)

_____ _____
(Signature) (Date)

State of: State of. County of: County of.

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐online notarization, this Day day of Month, 20Year by By., and: ☐ who is personally known to me, or ☐ who produced the following identification: Produced the following identification..

[SEAL]

_____
Notary Public

_____
Printed Notary Name

_____
My Commission Expires

Applicant Company Name: Applicant Company Name
NAIC No.:NAIC No. FEIN: 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 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 and Address. **[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. **[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.
(Printed Full Name and Residence Address)

_____ _____
(Signature) (Date)

State of: State of. County of: County of.

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐online notarization, this Day day of Month, 20Year by By., and: ☐ who is personally known to me, or ☐ who produced the following identification: Produced the following identification..

[SEAL]

_____
Notary Public

_____
Printed Notary Name

_____
My Commission Expires

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.

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