



Florida Office of Insurance Regulation

APPLICATION FOR EXPANSION OF A CERTIFICATED CONTINUING CARE FACILITY

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 <http://www.floir.com/iportal> and select "Form & Rate Filing Assembly and Submission" 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:

<http://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.

APPLICATION FOR EXPANSION OF A CERTIFICATED CONTINUING CARE FACILITY

INSTRUCTIONS

A provider is only required to file this application for approval of an expansion in the following circumstances:

- (1) The expansion is equivalent to the addition of at least 20% of existing units, and the provider has not exceeded the current statewide median for days cash on hand, debt service coverage ratio, and total facility occupancy for the most recent two consecutive annual reporting periods, or
- (2) For a provider that has exceeded the current statewide median for days cash on hand, debt service coverage ratio, and total facility occupancy for the most recent two consecutive annual reporting periods, the expansion is equivalent to an increase greater than 35% of existing units.

Existing units means the sum of the total number of independent living units and assisted living units identified in the most recent annual report filed with the Office, pursuant to Section 651.026, Florida Statutes. Skilled nursing units should not be included in the calculation. Note that these expansion approval requirements do not apply to construction for which a certificate of need from the Agency for Health Care Administration is required.

If the provider exceeds the statewide median for days cash on hand, debt service coverage ratio, and total facility occupancy for the most recent two consecutive annual reporting periods, the provider is automatically granted approval to expand the total number of existing units by up to 35% upon submitting a letter to the Office indicating the total number of planned units in the expansion, the proposed sources and uses of funds, and an attestation that the provider understands and pledges to comply with all minimum liquid reserve and escrow account requirements.

The statewide median for days cash on hand, debt service coverage ratio, and total facility occupancy is the median calculated in the most recent annual report submitted by the Office to the Continuing Care Advisory Council pursuant to Section 651.121(8), Florida Statutes.

APPLICATION FOR EXPANSION OF A CERTIFICATED CONTINUING CARE FACILITY

SECTION I – FEES

Section I-1 **Fingerprint Processing Fees**

Applicants are required to pay a fee for the processing of the fingerprint cards required in Section IV-4. Please see Form OIR-C1-938, Fingerprint Payment and Submission Procedure, for instructions.

SECTION II – LEGAL

Section II-1 **Authorization Letter**

Provide a letter of authorization for anyone other than company personnel or the company-sponsoring agent, designating the named individual to represent the Applicant.

Section II-2 **Certificate of Status**

Submit a certificate of status dated within the last year. A certificate of status is a document issued by the public official having supervision of the records of corporations in the Applicant's home state or jurisdiction of domicile, usually the Secretary of State or equivalent office, that shows the company is duly organized in the state or jurisdiction of domicile and that all taxes and fees have been paid.

Section II-3 **Changes to Any Previously Submitted Legal Documents**

If there have been any revisions, amendments, or other changes to previously filed legal documents (listed in the Checklist under Legal) and those documents have not been submitted to the Office, please submit the revised documents or amendments. If the revised documents or amendments required certification, a properly certified document or amendment should be provided. If none of the previously provided documents have been revised, amended, or otherwise changed, submit a statement that there have been no revisions, amendments, or other changes to any previously provided legal documents and that there are no new documents to submit.

APPLICATION FOR EXPANSION OF A CERTIFICATED CONTINUING CARE FACILITY

SECTION III – FINANCIAL

Section III-1 Plan of Operations

Submit a general summary of the plan of operations of Applicant. The plan should include management structure, healthcare delivery system, and a description of the types of continuing care contracts offered, including health care benefits and refundable contract options. Be sure to include a description of the facility after the expansion and any changes to the healthcare delivery system. This plan should be consistent with the feasibility study.

Section III-2 Interrogatories

Submit complete responses to all interrogatories attached as Exhibit III-2.

Section III-3 Feasibility Study

Submit an independent feasibility study that complies with the requirements of Section 651.0246(2)(a), Florida Statutes. The Application Checklist below lists the required components of the feasibility study.

The provider may submit any other information it deems relevant and appropriate to enable the Office to make a more informed determination. If such information is submitted, please provide an explanation of why the additional information is relevant and appropriate for the Office to consider in reviewing the application filing.

Section III-4 Financial Ratio Projections

Please provide a projected days cash on hand, occupancy, and debt service coverage ratio calculations for the first 5 years of operations of the expansion. Please explain when the provider anticipates meeting the minimum requirements provided in Sections 651.011(15) or 651.011(25), Florida Statutes. These projections should be consistent with the feasibility study.

Section III-5 Minimum Liquid Reserve Projections

Provide a projected calculation of the facility's minimum liquid reserves for the first 5 years of operations of the expansion and a description of how Applicant will fund the minimum liquid reserves. These projections should be consistent with the feasibility study.

Section III-6 Funding Plan and Supporting Documents

Furnish a Sources and Uses of Funds statement explaining the projects proposed method of financing and disclosing all sources and all uses of funds to be used to develop the expansion. The statement should describe construction and long-term financing for the facility.

APPLICATION FOR EXPANSION OF A CERTIFICATED CONTINUING CARE FACILITY

Please provide available documentation regarding the Sources and Uses of Funds statement. This includes financing commitments, letters of intent to finance, term sheets, or other agreements or similar documents with affiliates, lenders, or underwriters regarding funding for the proposed facility. Please note if the documents are drafts or in final form. Provide executed copies for any agreements that are already in-force. If no such documents exist at this time, please provide a statement that such documentation is not available at this time.

If agreements have not been executed at the time of filing, please provide an explanation of the conditions precedent to the parties executing the various agreements and a timeline of when the agreements are expected to be executed.

Note that the aggregate amount of entrance fees received by or pledged to the Applicant, plus anticipated proceeds from any long-term financing commitment, and funds from all other sources in the actual possession of the Applicant, must equal at least 100% of the aggregate cost of constructing or purchasing, equipping, and furnishing the facility plus 100% of the anticipated startup losses of the expansion.

Note that the Office may not approve an application that includes in the plan of financing any encumbrance of the operating reserves or renewal and replacement reserves required by Chapter 651, Florida Statutes.

Section III-7 Escrow Agreements

Submit draft escrow agreements for any new escrow account that will be established in connection with the proposed expansion. If the Applicant will use existing escrow accounts to meet the requirements of Sections 651.0246 and 651.035, Florida Statutes, please indicate which accounts will be used.

Note that in order to secure initial reservation deposits and entrance fees in accordance with Sections 651.0246(3) and (4), Florida Statutes, reservation deposits and entrance fees associated with the expansion should be held in a separate account or subaccount than funds received for existing units.

If the provider will have outstanding indebtedness related to the expansion that requires a debt service reserve to be held in escrow pursuant to a trust indenture or mortgage lien on the facility and for which the debt service reserve may only be used to pay principal and interest payments on the debt that the debtor is obligated to pay, pursuant to Section 651.035(1)(b), Florida Statutes, such an escrow account may be included in its debt service reserves. Please explain if Applicant will have such a debt service reserve related to the expansion and provide supporting documentation. After approval of the expansion, for such an account to be applied to debt service reserves, the provider must furnish a copy of the agreement under which such debt service is held and a statement of the amount being held in escrow for the debt service reserve certified by the lender or trustee and the provider to be correct.

APPLICATION FOR EXPANSION OF A CERTIFICATED CONTINUING CARE FACILITY

Section III-8 Continuing Care Contracts

Provide copies of each continuing care contract, reservation agreement, waitlist agreement, and addendum, to be entered into between the Applicant and residents of the expansion, which must meet the minimum requirements of Sections 651.022, 651.023, 651.055, and 651.061 Florida Statutes, unless such contracts have previously been reviewed and approved by the Office. The contracts for the expansion must include a statement describing the procedures required by law relating to the release of escrowed entrance fees. Such a statement may be furnished through an addendum.

Please provide a listing of all the continuing care contracts currently offered at the facility.

Please note that continuing care contracts must be approved by the Office before use. Review and approval of the continuing care contract forms, reservation agreements, and addendums to such agreements is independent of the application process. Any new resident contract forms the Applicant intends to use regarding the expansion must also be submitted for review through the IRFS portal.

Section III-9 Contractors, Vendors, Services, and Other Agreements

Furnish copies of any new agreements related to the expansion whereby the Applicant accepts obligations, debts, and encumbrances which would affect the facility.

Submit copies of any new contract entered into or to be entered into by the Applicant in relation to marketing, construction, long-term financing, leases of land or property, or management of the facility and the provision of shelter, food, and health care to residents. For example, management agreements, leases, development agreements, etc.

Please indicate if any person specified in Section 651.022(2)(b)1.-10., Florida Statutes, owns any interest in or receives any remuneration from, directly or indirectly, any professional service firm, association, trust, partnership, or corporation providing goods, leases, or services to the facility for which the application is made, with a real or anticipated value of \$10,000 USD or more.

If so, provide the name and address of the professional service firm, association, trust, partnership, or corporation in which such interest is held; describe such goods, leases, or services; the probable cost to the facility or provider; and why such goods, leases, or services should not be purchased from an independent entity. Explain whether the contract or arrangement is the result of arms-length negotiations, a bid, or otherwise. If no person meets these conditions, please provide a statement to that effect.

Additionally, furnish copies of any other agreements referenced in this filing.

APPLICATION FOR EXPANSION OF A CERTIFICATED CONTINUING CARE FACILITY

Section III-10 Advertisements

Furnish the form of any advertisement or other written material proposed to be used in the solicitation of residents.

APPLICATION FOR EXPANSION OF A CERTIFICATED CONTINUING CARE FACILITY

SECTION IV – MANAGEMENT

Section IV-1 **Management Information Forms**

Please submit Management Information Forms fully describing the management, ownership, and control of the provider up to and including any 10% or greater owners of the ultimate parent. A Management Information Form should be submitted for each entity in the ownership chain.

Forms should contain the first, middle, and last name of each officer, director, and 10% or greater owner of the entity named on the form. The Management Information Form is included in the packet.

Section IV-2 **Biographical Affidavits as to Officers, Directors, and Shareholders**

For individuals named on the Management Information Forms who have not previously submitted Biographical Affidavits, provide a National Association of Insurance Commissioners (“NAIC”) Biographical Affidavit (NAIC Form 11) for each officer, director, and shareholder listed in Section IV-1. Applicant may omit officers, directors, and shareholders of those companies in the organizational structure between the immediate parent and the ultimate parent. Please note that if an individual has a Biographical Affidavit on file with the Office, and the Biographical Affidavit was signed and notarized within 2 years of the date of the Application being filed, a Biographical Affidavit need not be submitted for that individual.

All questions must be answered. All “Yes” answers must be explained. Please note Item 8 of the NAIC Biographical Affidavit requires 20 years of employment history.

Each Biographical Affidavit must be signed and notarized.

The affiant’s social security number must be submitted to the Office. 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 to insure that the owners, management, officers, and directors of any entity regulated by the Office 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.

However, 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, and must be segregated on a separate page. Therefore, please include the affiant’s name and social security number on the separate page marked CONFIDENTIAL and provided in this packet, and attach that page to the NAIC Biographical Affidavit (NAIC Form 11) that is also included in this packet.

APPLICATION FOR EXPANSION OF A CERTIFICATED CONTINUING CARE FACILITY

Section IV-3 Background Investigative Report

For individuals named on the Management Information Forms who have not previously submitted a Background Investigative Report, a Background Investigative Report must be provided for each person for whom a Biographical Affidavit is required, as described above. Background Investigative Reports must be submitted by an approved background investigation vendor directly to the Office. Attach proof of payment confirming that all background reports have been ordered when submitting the application. Please refer to Form OIR-C1-905, Instructions for Furnishing Background Investigative Reports, included in this packet.

Section IV-4 Fingerprint Cards

For individuals named on the Management Information Forms who have not previously submitted Fingerprint Cards, Fingerprint Cards must be provided to the Office for each person for whom a Biographical Affidavit is required. Please refer to Form OIR-C1-938, Fingerprint Payment and Submission Procedure, for instructions. If an individual has submitted a fingerprint card dated within 5 years of the date of the Application filing, a fingerprint card need not be submitted for that individual.

APPLICATION FOR EXPANSION OF A CERTIFICATED CONTINUING CARE FACILITY

CHECKLIST

Applicant Name: _____

Federal Identification Number: _____

Home Office Address: _____
(Street Address) (City) (State) (Zip Code)

Phone Number: _____

Please complete and check off all items prior to submission. Applicant should provide an explanation for any items that have not been checked off and submitted.

Please note that if any material change occurs in the facts set forth in this application while it is pending before the Office, an amendment setting forth such change must be filed with the Office within 10 business days after the Applicant becomes aware of such change, and a copy of the amendment must be sent by registered mail to the principal office of the facility and to the principal office of the controlling company. Submit copies of the registered mail return receipts when filing with the Office.

SECTION I – FEES

- 1. All fingerprint fees paid electronically
- a. Copies of online payment confirmation

APPLICATION FOR EXPANSION OF A CERTIFICATED CONTINUING CARE FACILITY

CHECKLIST

SECTION II – LEGAL

- 1. Authorization Letter
- 2. Certificate of Status
- 3. Updates or amendments to any previously submitted legal documents, or statement of no changes made and no documents to submit

Legal Documents Previously Submitted (for reference):

- a. Organizational Documents
 - i. Certified by the Secretary of State (if applicable)
- b. Bylaws
 - i. Certified by corporate Secretary
- c. Certificate of Status
- d. Fictitious Name Filing (if applicable)
- e. Parent Companies and Controlling Partners
 - i. Organizational Documents
 - Certified by the Secretary of State (if applicable)
 - ii. Bylaws
 - Certified by corporate Secretary
 - iii. Certificate of Status
 - iv. Fictitious Name Filing (if applicable)
 - v. Organizational Charts
 - With ownership percentages
- f. Service of Process Form (Form OIR-C1-144)

APPLICATION FOR EXPANSION OF A CERTIFICATED CONTINUING CARE FACILITY

CHECKLIST

SECTION III – FINANCIAL

- 1. Plan of Operations
- 2. Interrogatories, Exhibit III-2
- 3. Feasibility Study
 - a. Prepared by an independent certified public accountant
 - b. Indicate the page number where each of the following required elements is located within the feasibility study:

A description of the facility and proposed expansion, including:	pg _____
The location	pg _____
The size	pg _____
The healthcare delivery system	pg _____
The anticipated completion date	pg _____
The proposed construction program	pg _____
The primary market area	pg _____
The secondary market area, if applicable	pg _____
Projected unit sales per month	pg _____
Projected revenues, including:	pg _____
Anticipated entrance fees	pg _____
Monthly service fees	pg _____
Nursing care revenues, if applicable	pg _____
Other sources of revenue	pg _____
Projected expenses, including:	pg _____
Staffing requirements and salaries	pg _____
Cost of property, plant, and equipment	pg _____
Depreciation expense	pg _____
Interest expense	pg _____
Marketing expense	pg _____
Other operating expense	pg _____
Projected balance sheet of the Applicant, including	pg _____
Expectations for the financial condition of the project, including	pg _____

APPLICATION FOR EXPANSION OF A CERTIFICATED CONTINUING CARE FACILITY

Projected cash flow statement pg _____

Estimate of funds necessary to cover startup losses pg _____

Inflation factor, if any, and a statement of how and where it is applied pg _____

Project costs pg _____

Total amount of debt financing required pg _____

Marketing projections pg _____

Resident rates, fees, and charges pg _____

The breakeven point pg _____

The competition pg _____

Resident contract provisions, including: pg _____

 Description of contracts in-force at or offered by the facility pg _____

 Description of contracts to be offered related to the expansion pg _____

 Total amount of contractual liability attributable to refundable contracts pg _____

Other factors that may affect the feasibility of the facility pg _____

Appropriate population projections, including: pg _____

 Morbidity assumptions pg _____

 Mortality assumptions. pg _____

The assumptions used in the study, if any pg _____

The name of the person who prepared the feasibility study and their experience
in preparing similar studies or otherwise consulting in the field of continuing
care pg _____

Financial forecasts or projections prepared in accordance with standards
adopted by the American Institute of Certified Public Accountants or in
accordance with standards for feasibility studies for continuing care retirement
communities adopted by the Actuarial Standards Board. pg _____

If the study is prepared by an independent certified public accountant, it
must contain an examination opinion or a compilation report containing a
financial forecast or projections for the first 5 years of operations which
take into account an actuary's mortality and morbidity assumptions
as the study relates to turnover, rates, fees, and charges. pg _____

APPLICATION FOR EXPANSION OF A CERTIFICATED CONTINUING CARE FACILITY

In addition to the list above, any other information that the Applicant deems relevant and appropriate to enable the Office to make a more informed determination may be included in the feasibility study

- 4. Financial Ratio Projections**
 - a.** Days cash on hand
 - b.** Debt service coverage ratio
 - c.** Occupancy
- 5. Minimum Liquid Reserve Projections and Funding**
 - d.** Debt Service Reserve
 - e.** Operating Reserve
 - f.** Renewal and Replacement Reserve
- 6. Funding Plan and Supporting Documents**
 - g.** Sources and Uses of Funds
 - h.** Financing agreements
 - i.** Bond documents (if applicable)
- 7. Escrow Agreements**
- 8. Continuing Care Contract**
- 9. Contractors, Vendors, Services, and Other Agreements**
 - a.** Marketing agreements
 - b.** Development or construction contracts
 - c.** Construction or long-term financing agreements
 - d.** Leases of land or property
 - e.** Management agreements
 - f.** Contracts related to the provision of the following to residents

APPLICATION FOR EXPANSION OF A CERTIFICATED CONTINUING CARE FACILITY

- i. Shelter
- ii. Food
- iii. Health care to residents
- g. Affiliated contracts pursuant to Section 651.022(2)(b)8., Florida Statutes
- 10. Advertisements

APPLICATION FOR EXPANSION OF A CERTIFICATED CONTINUING CARE FACILITY

CHECKLIST

SECTION IV – MANAGEMENT

- 1. Management Information Forms submitted for all required entities
- 2. Biographical affidavits submitted for all required individuals
 - a. All information completed (no blanks)
 - b. "Yes" answers explained
 - c. Signed
 - d. Notarized
- 3. Background investigative reports for all required individuals. The reports must be based on the Biographical Affidavits submitted to the Office with this Application.
 - a. Proof of order and confirmation of payment submitted to the Office
- 4. Fingerprint cards for all required individuals
 - a. All information completed (no blanks)
 - b. Signed

APPLICATION FOR EXPANSION OF A CERTIFICATED CONTINUING CARE FACILITY

EXHBIT III-2

INTERROGATORIES

1. The Applicant is:

Applicant Name: _____

Federal Identification Number: _____

Home Office Address: _____
(Street Address) (City) (State) (Zip Code)

Phone Number: _____

2. The contact person for the Applicant is:

Name: _____

Employer: _____

Address: _____
(Street Address) (City) (State) (Zip Code)

Phone Number: _____

Email Address: _____

3. The continuing care facility that is the subject of this application is:

Facility Name: _____

Address: _____
(Street Address) (City) (State) (Zip Code)

APPLICATION FOR EXPANSION OF A CERTIFICATED CONTINUING CARE FACILITY

4. Please provide management’s calculation of the following measures, as defined by Chapter 651.011, Florida Statutes.

	As of the Last Submitted Annual Report	As of the Prior Annual Report
Debt Service Coverage Ratio		
Days Cash on Hand		
Occupancy		

5. As of the most recent annual report filed with the Office, provide the breakdown below of each type of unit at the facility.

	Occupied – CCRC Contract	Occupied – Rental	Under Construction/ Unavailable for Occupancy	Vacant	Total
Independent Living					
Assisted Living (including Memory Care)					
Skilled Nursing					

6. If one or more fiscal quarters have passed since the as of date of the most recent annual report filed with the Office, provide the breakdown below of each type of unit at the facility as of the most recent quarter.

	Occupied – CCRC Contract	Occupied – Rental	Under Construction/ Unavailable for Occupancy	Vacant	Total
Independent Living					
Assisted Living (including Memory Care)					
Skilled Nursing					

As of date for the information above: _____.

APPLICATION FOR EXPANSION OF A CERTIFICATED CONTINUING CARE FACILITY

7. Provide the number of units to be constructed in all phases of the proposed expansion:

Unit Type	Number of Units
Independent Living	
Assisted Living	
Skilled Nursing	
Rental	

8. Will the expansion be built in phases? Yes No

If so, please provide a breakdown of the number of units to be added at each phase of the expansion. If more than three phases are contemplated, please attach a table showing the units to be added in each phase.

	Phase 1	Phase 2	Phase 3
Independent Living			
Assisted Living (including Memory Care)			
Skilled Nursing			

9. Office approval is required for the addition of at least 20% of existing units. Existing units means the sum of the total number of independent living units and assisted living units identified in the most recent annual report filed with the Office, pursuant to Section 651.026. Skilled nursing units should not be included in the calculation.

The expansion proposed in this application represents a _____% increase in existing units.

APPLICATION FOR EXPANSION OF A CERTIFICATED CONTINUING CARE FACILITY

APPLICATION CERTIFICATION

The below certification must be executed by two officers of Applicant, one of whom must be the President or Chief Financial Officer, and the other the Secretary*.

The undersigned state that they are officers having personal knowledge of this application submitted to the Florida Office of Insurance Regulation by _____ ("Applicant"), that they have read said application, and that they know the contents thereof and verify that the items indicated in the application checklist are true and complete to the best of their knowledge and have been submitted with the application. The undersigned represent that they have the authority to bind the Applicant, and that by their signatures on the instrument, the Applicant on behalf of which they have 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, punishable as provided in Section 775.082 or Section 775.083, Florida Statutes.

By: _____

Print Name: _____

Title: _____

Date: _____

By: _____

Print Name: _____

Title: _____

Date: _____

*Other officers, or similar persons with the authority to bind Applicant, will be accepted only if the Applicant does not have these positions.



Florida Office of Insurance Regulation

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@flor.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@flor.com (Property and Casualty applicants) or to lhappcoord@flor.com (Life and Health applicants).



Florida Office of Insurance Regulation

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/>, select "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@floi.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 system(s) of records in which that agency may also maintain your records, including the authorities, purposes, and routine uses for the system(s).



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

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:

<u>College/University</u>	<u>City/State</u>	<u>Dates Attended</u> (MM/YY)	<u>Degree</u> <u>Obtained</u>
---------------------------	-------------------	----------------------------------	----------------------------------

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

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

Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number 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:

<u>Name of Society/Association</u>	<u>Contact Name</u>	<u>Address of Society/Association</u>	<u>Telephone Number of Society/Association</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

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

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

- 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.

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

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.

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

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

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

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

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

____ 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: _____

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: _____

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.