

69O-203.010 Scope.

The following rules developed by the Office of Insurance Regulation govern the issuance of a Certificate of Authority and the operation of a prepaid limited health service organization pursuant to the authority set forth in chapter 636, F.S.

Rulemaking Authority 636.067 FS. Law Implemented Chapter 636 FS. History–New 11-15-94, Formerly 4-203.010. Repealed.

69O-203.013 Definitions for the Purpose of These Rules.

(1) All terms defined in the Prepaid Limited Health Service Organization Act, chapter 636, F.S., which are used in these rules shall have the same meaning as in the Act.

(2) Advertising. This includes, ~~but is not limited to,~~ printed and published material, descriptive literature and sales aids, sales talks and sales materials, booklets, forms and pamphlets, illustrations, depictions and form letters, newspaper, radio, television, or direct mail advertising. This includes any material or information intended to solicit or induce membership or the purchase of a limited health service plan.

(3) Co-payment. A specific dollar amount or percentage discount as specified in a subscriber contract, except as otherwise provided for by statute, that the subscriber must pay upon receipt of covered health care services.

(4) Emergency Services. Services which are needed immediately because of an injury or unforeseen medical condition as provided for in the Subscriber Contract.

(5) PLHSO. Prepaid Limited Health Service Organization shall be abbreviated as PLHSO in these rules.

(6) Premium. The contracted sum paid by or on behalf of a subscriber or group of subscribers on a prepaid per capita or a prepaid aggregate basis for limited health services rendered by or through the PLHSO.

~~(7) Complete Application. An application for a certificate of authority that contains all of the items specified in rule 69O-203.020, F.A.C., and Form OIR-1119 (rev. 8/94) “Application for Certificate of Authority,” incorporated by reference in rule 69O-203.100, F.A.C. The application must be completed in accordance with Chapter 636, F.S., and these rules in the manner specified within the application in order for each individual item to be considered complete for the purpose of determining that a properly completed application has been filed.~~

~~(7)(8) Waiting Period. Waiting period shall relate to that period of time which may be specified in the contract and which must follow the date a person is initially covered under the contract before coverage shall become effective as to such person.~~

~~(8)(9) Pre-Existing Condition or Illness. A condition, or symptoms thereof, which was diagnosed and for which the individual received medical advice or treatment from a physician within a 3 month period preceding the effective date of coverage.~~

~~(9)(10) Prepayment. Any premium paid by or on behalf of a subscriber which entitles the subscriber to access to limited health services.~~

Rulemaking Authority 636.067 FS. Law Implemented 636.003, 636.008, 636.009, 636.015, 636.016 FS. History–New 11-15-94, Formerly 4-203.013. Amended

69O-203.020 Prepaid Limited Health Service Organization Application for Certificate of Authority.

Substantial rewording of Rule 69O-203.020, F.A.C. follows. See Florida Administrative Code for present text.

(1) A person applying for a certificate of authority as a prepaid limited service organization shall submit the following:

(a) Form OIR-C1-1119, “Application for Certificate of Authority Prepaid Limited Health Service Organization,” effective 6/20, hereby incorporated by reference and available at www.flrules.org/XXXXX;

(b) Form OIR-C1-905, “Instructions for Furnishing Background Investigative Reports,” effective 6/20, hereby incorporated by reference and available at www.flrules.org/XXXXX;

(c) Form OIR-C1-938, “Fingerprint Payment and Submission Procedures,” effective 6/20, hereby incorporated by reference and available at www.flrules.org/XXXXX;

(d) Form OIR-1423, “Biographical Affidavit,” effective 6/20, hereby incorporated by reference and available at www.flrules.org/XXXXX.

(2) A person shall submit the forms listed in subsection (1) electronically via the Office’s iApply system at <https://www.floir.com/iportal>.

~~An application, Form number OIR C1 1119, incorporated by reference, in rule 69O 203.100, F.A.C., accompanied by the appropriate filing fee, shall be completed by each entity desiring to obtain a certificate of authority as a PLHSO. The applicant shall specify in the application the contact person or persons for the PLHSO for purposes of corresponding between the Office and the PLHSO concerning the application. During the investigation of the application, only contact persons specified by the PLHSO shall be permitted access to the application materials submitted. The applicant shall address correspondence to the Application Coordination Section, Insurer Services Support, Office of Insurance Regulation, Tallahassee, Florida 32399 0332. The Office shall accept and begin its investigation of an application promptly after receiving it. All application reviews will be conducted pursuant to chapter 120, F.S.~~

Rulemaking Authority 636.067 FS. Law Implemented 636.005, 636.007, 636.008, 636.009 FS. History—New 11-15-94, Formerly 4-203.020. Amended _____.

69O-203.021 Standards for Fingerprint Cards for New Applicants and Acquisition Applications.

~~(1) Fingerprints shall be submitted only on a card, for which instructions are adopted in subsection 69O-203.100(9), F.A.C., provided by the Office of Insurance. Others will not be accepted.~~

~~(2) The Office has adopted Form OIR-938 (rev. 4/91), incorporated by reference in rule 69O-203.100, F.A.C., which provides instructions on how fingerprint cards are to be completed.~~

Rulemaking Authority 636.067 FS. Law Implemented 636.007, 636.008 FS. History—New 11-15-94, Formerly 4-203.021. Repealed, _____.

69O-203.065 Reinsurance (Excess Loss Insurance).

PLHSOs may obtain reinsurance (excess loss insurance) in order to limit the PLHSO's financial risk. All excess loss or reinsurance contracts shall be filed with and approved by the Office. In addition to the regular insurance filing of any reinsurance (excess loss insurance) contract, if the reinsurance (excess loss insurance) contract contains insolvency protection for the PLHSO, the contract shall be submitted for prior approval to the Office of Insurance Regulation, Life and Health Financial Oversight, electronically through <http://www.flair.com/iportal>, Bureau of Life and Health Insurer Solvency Office of Insurance Regulation, Tallahassee, Florida 32399-0327.

Rulemaking Authority 636.067 FS. Law Implemented 636.009 FS. History—New 11-15-94, Formerly 4-203.065. Amended _____.

69O-203.070 Annual and Quarterly Reports.

~~(1) Each PLHSO shall file with the Office a full and true report of its financial condition, transactions, and affairs.~~

~~(a) An Annual Report covering the preceding fiscal year shall be filed on or before April 1 or within 3 months of the end of the reporting period of the clinic. Pursuant to Section 636.043, F.S., each PLHSO shall furnish to the Office an annual report by April 1, or within 3 months after the end of the reporting period on NAIC Annual Statement Health Blanks as adopted in Rule 69O-137.001, F.A.C.~~

~~1. The Annual Report shall be transmitted electronically to the National Association of Insurance Commissioners and that the executed Jurat page of said report has been transmitted electronically to the Office via the Regulatory Electronic Filing System, "REFS." The date affixed by the Office's electronic data processing system shall serve as evidence of the timeliness of the Annual Report. An Annual Report in any other format shall not be submitted to the Office.~~

~~2. Each PLHSO shall submit its Annual Report electronically to the National Association of Insurance Commissioners in accordance with the electronic filing instructions incorporated by reference in paragraph 69O-137.001(3)(b), F.A.C.~~

~~3. The Annual Report shall be prepared in accordance with the manuals incorporated by reference in paragraph 69O-137.001(4)(a), F.A.C.~~

~~4. Copies of the manuals are available:~~

~~a. From the National Association of Insurance Commissioners at <http://www.naic.org>; and,~~

~~b. For inspection during regular business hours at the Office of Insurance Regulation, Larson Building, 200 East Gaines Street, Tallahassee, Florida 32399-0300.~~

~~(b) Form OIR-A2-949, "Annual Report Contracts Issued & Outstanding," effective 12/20, hereby incorporated by reference and available [www.flrules.org/XXXXX](http://www.flrules.org). Form OIR-A2-949 shall be submitted electronically on or~~

before April 1 or within 3 months of the end of the reporting period of the clinic via the Office's system at <https://www.floir.com/iportal>.

(c) Form OIR-A2-950, "Annual Report Damage Claims & Medical Injury," effective 12/20, hereby incorporated by reference and available at www.flrules.org/XXXXX. Form OIR-A2-950 shall be submitted electronically on or before April 1 or within 3 months of the end of the reporting period of the clinic via the Office's system at <https://www.floir.com/iportal>.

(d)(b) The completed ~~Annual Reports annual statement form~~ shall be accompanied by the items required in section 636.043, F.S., and an organization chart of the PLHSO identifying ownership and affiliated parent and subsidiary companies.

(2) Each PLHSO ~~or applicant~~ shall notify the Office of any legal proceeding, excluding traffic infractions, involving any person subject to providing biographical information. This shall include, ~~but not be limited to,~~ any and all criminal, civil, and administrative actions entered by any state or federal entity and to include pending but yet unresolved actions.

(3) Any PLHSO which has operations in states other than Florida shall file its ~~Annual Report annual report~~ based upon its total operations. In addition, the PLHSO shall file a separate schedule of all financial statements specified in the ~~Annual Report annual report form~~, including the audited financial statement, which covers the Florida operations only.

(4) If a PLHSO constitutes a portion of or a division of a certificated entity, the entity shall file its ~~Annual Report annual report~~ based upon its total operations. In addition, the entity shall file a separate schedule of all financial statements specified in the ~~Annual Report annual report form~~, including the audited financial statement, which covers the PLHSO operation only.

(5) The ~~Annual Report annual report~~ shall include disclosure of material transactions between the PLHSO and a related party. The disclosure shall include:

(a) The nature of the relationship(s) involved.

(b) A description of the transaction, including transactions to which no amounts or nominal amounts were ascribed, for each of the periods for which income statements are presented, and such other information deemed necessary to an understanding of the effects of the transaction on the financial statements.

(c) The dollar amounts of transactions for each of the periods for which income statements are presented and the effects of any change in the method of establishing the terms from that used in the preceding period.

(d) Amounts due from or to related parties as of the date of each balance sheet presented and, if not otherwise apparent, the terms and manner of settlement.

(6) Quarterly reports shall be submitted to the Office within forty-five (45) days following the end of each operating quarter. The initial operating quarter commences after the issuance of a certificate of authority. Quarterly reports shall be submitted in accordance with section 636.043, F.S., on NAIC Quarterly Statement Health Blanks, as adopted in rule 69O-137.001, F.A.C., and shall contain the following supplemental schedules:

(a) A complete identification and dollar value breakdown of all short term investments with individual balances greater than 10% of total short term investments;

(b) A complete list of all debtors with account balances greater than 10% of total prepaid expenses;

(c) An aging analysis on all premium receivables;

(d) A complete aging, identification, and dollar value breakdown of all prepaid expenses with individual balances greater than 10% of total prepaid expenses;

(e) A complete identification and dollar value breakdown of all restricted assets and restricted funds with individual balances greater than 10% of the respective account balance total;

(f) A complete identification and dollar value breakdown of all long term investments with individual balances greater than 10% of total long term investments;

(g) A complete identification and dollar value breakdown of other assets with individual balances greater than 10% of total other assets; and

(h) All surplus notes shall be identified by a complete identification and dollar value breakdown and shall be accompanied by a copy of the surplus note agreement. Each PLHSO is required to submit four (4) quarterly reports in addition to an annual report each fiscal year.

Rulemaking Authority 636.067 FS. Law Implemented 636.009(1)(f), 636.043, ~~636.058 626-058~~ FS. History—New 11-15-94, Formerly 4-203.070, Amended 9-16-08. Amended _____.

690-203.078 Fees.

Checks for the original application filing or amendments thereto, for filing of each annual report, and for any other fees collected pursuant to these rules or chapter 636, F.S., shall be made payable to the Florida Department of Financial Services, "Chief Financial Officer, State of Florida."

Rulemaking Authority 636.067 FS. Law Implemented 636.057 FS. History—New 11-15-94, Formerly 4-203.078. Amended _____.

690-203.093 Change of Ownership.

Change of ownership shall comply with section 628.4615, F.S., and the transaction shall be reviewed and approved by the Office as provided therein. The acquisition application shall be submitted on form OIR-C1-448, which is incorporated by reference in rule 690-203.100, F.A.C.

Rulemaking Authority 636.067 FS. Law Implemented 636.065, 628.4615 FS. History—New 11-15-94, Formerly 4-203.093. Repealed, _____.

690-203.100 Prescribed Forms.

The forms listed below are incorporated herein, and made a part of, these rules by reference:

Title	Form Number
(1) Application for Certificate of Authority Prepaid Limited Health Service Organization	OIR-C1-1119 http://www.flrules.org/Gateway/reference.asp?No=Ref 08282 (12/05)
(2) Invoice—Request for Payment of Fingerprint Charges	OIR-C1-903 http://www.flrules.org/Gateway/reference.asp?No=Ref 08290 (12/05)
(3) Biographical Affidavit	OIR-C1-1423 http://www.flrules.org/Gateway/reference.asp?No=Ref 01063 (8/14)
(4) Authority for Release of Information	OIR-C1-450 http://www.flrules.org/Gateway/reference.asp?No=Ref 08301 (5/00)
(5) Service of Process Consent and Agreement	OIR-C1-144 http://www.flrules.org/Gateway/reference.asp?No=Ref 08280 (06/04)
(6) Instructions for Furnishing Background Investigative Reports	OIR-C1-905 http://www.flrules.org/Gateway/reference.asp?No=Ref 08301 (2/15)
(7) Fingerprint Payment and Submission Procedure	OIR-C1-938 http://www.flrules.org/Gateway/reference.asp?No=Ref 08296 (5/13)
(8) Statement of Acquisition merger of Consolidation of a Specialty Insurer Pursuant to Sections 628.461, 628.4615, F.S.	OIR-C1-448 http://www.flrules.org/Gateway/reference.asp?No=Ref 08281 (12/05)
(9) Annual Report Supplement—Contracts Issued and Outstanding	OIR-A2-949 http://www.flrules.org/Gateway/reference.asp?No=Ref 08278 (7/04)
(10) Annual Report Supplement—Damage Claims & Medical Injury	OIR-A2-950 http://www.flrules.org/Gateway/reference.asp?No=Ref 08279 (7/04)

All of the above forms may be obtained from the Office of Insurance Regulation's website: <http://www.flair.com/iportal>.

Rulemaking Authority 636.067 FS. Law Implemented 624.321(1)(a), 624.424, 636.005, 636.008, 636.009, 636.012, 636.043 FS. History—New 11-15-94, Formerly 4-203.100, Amended 7-30-17. Repealed, _____.

690-203.210 Discount Plan Organization Application Forms Incorporated by Reference.

Substantial rewording of Rule 690-203.210, F.A.C. follows. See Florida Administrative Code for present text.

(1) A person applying for a certificate of authority as a discount plan organization shall submit the following:

(a) Form OIR-C1-1606, "Application for License Discount Plan Organization (DPO)," effective 6/20, hereby incorporated by reference and available at <http://www.flrules.org/Gateway/reference.asp?No=Ref-10323>;

(b) Form OIR-C1-144, "Service of Process Consent & Agreement," effective 6/04, hereby incorporated by reference and available at <http://www.flrules.org/Gateway/reference.asp?No=Ref-10326>;

(c) Form OIR-C1-905, "Instructions for Furnishing Background Investigative Reports," effective 6/20, hereby incorporated by reference and available at <http://www.flrules.org/Gateway/reference.asp?No=Ref-10329>;

(d) Form OIR-C1-938, "Fingerprint Payment and Submission Procedures," effective 6/20, hereby incorporated by reference and available at <http://www.flrules.org/Gateway/reference.asp?No=Ref-10325>;

(e) Form OIR-C1-1423, "Biographical Affidavit," effective 6/20, hereby incorporated by reference and available at <http://www.flrules.org/Gateway/reference.asp?No=Ref-10324>; and

(f) Form OIR-C1-2221, "Management Information Form," effective 6/20, hereby incorporated by reference and available at <http://www.flrules.org/Gateway/reference.asp?No=Ref-10327>; and

(2) A person shall submit the forms listed in subsection (1) electronically via the Office's iApply system at <https://www.flair.com/iportal>.

(1) The following forms are hereby incorporated by reference:

(a) Form OIR-C1-1606, Application for License Discount Plan Organization (DPO), effective 01/18, available at <http://www.flrules.org/Gateway/reference.asp?No=Ref-10323>;

(b) Form OIR-C1-1423, Biographical Affidavit, effective 03/18, available at <http://www.flrules.org/Gateway/reference.asp?No=Ref-10324>;

(c) Form OIR-C1-938, Fingerprint Payment and Submission Procedure, effective 10/18, available at <http://www.flrules.org/Gateway/reference.asp?No=Ref-10325>;

(d) Form OIR-C1-144, Service of Process Consent & Agreement, effective 06/04, available at <http://www.flrules.org/Gateway/reference.asp?No=Ref-10326>;

(e) Form OIR-C1-1298, Management Information Form Complete List of Officers, Directors, and Shareholders (10% or more), effective 03/18, available at <http://www.flrules.org/Gateway/reference.asp?No=Ref-10327>; and

(f) OIR-A1-1671, Annual Report Discount Plan Organizations (05/18), available at <http://www.flrules.org/Gateway/reference.asp?No=Ref-10328>;

(g) Form OIR-C1-905, Instructions for Furnishing Background Investigative Reports, effective 02/15, available at <http://www.flrules.org/Gateway/reference.asp?No=Ref-10329>.

(2) All of the above referenced forms are available and may be printed from the Office of Insurance Regulation's website: <http://www.flair.com/iportal>.

Rulemaking Authority 624.424(1)(c), 636.232 FS. Law Implemented 624.424, 636.204, 636.218, 636.220, 636.226, 636.228, 636.234, 636.236 FS. History—New 5-22-05, Amended 10-29-08, 7-30-17, 4-11-19. Amended _____.

690-203.215 Annual Reports.

Annual Reports are to be filed with the Office within three months after the end of each fiscal year on Form OIR-A1-1671, "Annual Report – Discount Plan Organizations," effective 5/18, hereby incorporated by reference and available at www.flrules.org/XXXXX. The filings shall be submitted electronically via the Office's system at <https://www.flair.com/iportal>.

Rulemaking Authority 638.218(2), 636.232 FS. Law Implemented 636.218 FS. History—New _____.



**Office of Insurance Regulation
Life & Health Financial Oversight**

FLORIDA

COMPANY CODE:

FEDERAL EMPLOYER

IDENTIFICATION NUMBER

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**ANNUAL REPORT
OF THE**

NAME OF THE DISCOUNT PLAN ORGANIZATION (DPO)

(CITY)

(STATE)

**TO THE
OFFICE OF INSURANCE REGULATION
OF THE
STATE OF FLORIDA**

Life & Health Financial Oversight
200 East Gaines Street
Tallahassee, FL 32399 - 0327

FOR THE FISCAL YEAR ENDED

DUE ON OR BEFORE

3 MONTHS AFTER THE END OF EACH FISCAL YEAR END

REPORT MUST BE TYPED OR PRINTED

Name of Discount Plan Organization (DPO):

**Annual Report of DPO to the Florida Office of Insurance Regulation
For Fiscal Year Ending _____**

Federal Employer Identification Number (FEIN)	_ _ _ - _ - _ _ _ _ _ _ _ _		
Complete address of DPO's principal office			
Full name & title of DPO's chief executive officer			
Web Site (s. 636.204 (4))			
Type of entity (check one)	<input type="checkbox"/> Corporation - For profit <input type="checkbox"/> Sole proprietorship <input type="checkbox"/> Corporation - Not-for-profit <input type="checkbox"/> Limited liability company <input type="checkbox"/> Partnership <input type="checkbox"/> Other:		
<p>This annual report shall be signed below by two corporate officers of the DPO, if the DPO is a corporation; the DPO's partners, if the DPO is a partnership; the DPO's owner, if the DPO is a sole proprietorship; or the DPO's managing or other duly authorized member, if the DPO is a limited liability company.</p>			
Printed name		Printed name	
Title		Title	
Signature		Signature	

Instructions

1. Within 3 months after the end of each fiscal year, complete and file this report for the preceding fiscal year with:

The Office of Insurance Regulation
Life & Health Financial Oversight
200 E. Gaines Street
Tallahassee, Florida 32399-0327

2. Provide all requested information on page 2. Have the report signed on page 2 consistent with the instructions thereon.
3. Answer questions a through r on pages 4 and 5, as they pertain to the fiscal year covered by this report. Attach any additional information and/or documentation required as a result of your responses, clearly identifying each attachment and the question number being answered.
4. Attach a copy of the audited financial statements prepared in accordance with generally accepted accounting principles certified by an independent certified public accountant, including the organization's balance sheet, income statement, and statement of changes in cash flow for the preceding fiscal year.

An organization that is a subsidiary of a parent entity that is publicly traded and that prepares audited financial statements reflecting the consolidated operations of the parent entity and the organization may petition the office to accept, in lieu of the audited financial statement of the organization, the audited financial statement of the parent entity and a written guaranty by the parent entity that the minimum capital requirements of the organization required by this part will be met by the parent entity. The Office may accept this petition if all of the following are met:

- The licensee is 100% owned by the parent directly or indirectly
 - The parent receives an unqualified opinion
 - The parent's audited financial statement reflects at least a \$5 million net worth on a GAAP basis
 - The parent provides a parental guarantee The licensee provides un-audited financial statement on a GAAP basis attested to which reflects a surplus of \$150,000 or more.
 - Licensee requests petition in writing at least 30 days prior to due date of annual report
5. If different from the initial application or the last annual report, complete the schedule on page 7, and include the complete names, address, or Federal taxpayer identifying numbers, titles, and ownership percentages of all officers, directors, managing members, and 10% or greater owners, and for each indicate whether that individual is an officer, director, and/or owner. Please disclose the extent and nature of any contracts or arrangements between such persons and the DPO, including any possible conflicts of interest. Attach additional pages as needed.

Name of Discount Plan Organization (DPO):

**Annual Report of DPO to the Florida Office of Insurance Regulation
For Fiscal Year Ending _____**

6. For each individual who, during the period covered by this report, was a member of the DPO's Board of Directors, Board of Trustees, Executive Committee, or other governing board or committee, or who was one of its principal officers or managing members, responsible for the conduct of its affairs, or in a position to exercise control or influence over its affairs, **and for whom the DPO has not previously done so**, (1) make arrangements to have an investigation report forwarded directly to the Office, and (2) attach to this report: (a) a statement informing the Office of the date that such investigative report was requested, (b) completed NAIC Biographical Statement and Affidavit, and (c) two completed Florida fingerprint cards. Only Florida fingerprint cards will be accepted. Florida fingerprint cards may be obtained by calling the Office of Insurance Regulation, L&H Financial Oversight, at (850) 413-5052.

7. As stated in s.636.204(3), "The office shall issue a license which shall expire 1 year later, and each year on that date thereafter, and which the office shall renew if the licensee pays the annual license fee of \$50 and if the office is satisfied that the licensee is in compliance with this part." Attach evidence of your \$50 renewal fee being paid to the Department of Financial Services, Revenue Processing Section, P.O. Box 6100, Tallahassee, Florida 32314-6100. Page 8 of this report should be detached and mailed to the address given, along with your check for \$50, **prior to the anniversary date of the DPO obtaining its license**.

8. Answer the questions below as they pertain to the fiscal year covered by this report. Attach any additional information and/or documentation required as a result of your responses.

		Yes	No
a	Have there been any changes to any of the DPO's basic organizational documents, such as its bylaws or articles of incorporation? If so, attach an explanation of all such changes, and copies of the amended documents.		
b	Have there been any changes in the DPO's ownership? If so, attach a statement containing complete details, and an organizational chart depicting all direct and indirect relationships between the DPO and all of its affiliates, including the ultimate parent corporation of all such entities.		
c	Was the DPO a party to any civil or criminal legal action, other than as plaintiff in a civil matter? If so, attach a statement containing complete details.		
d	Is the DPO doing business in any state(s) other than Florida? If so, attach a schedule of all such state(s).		
e	Was the DPO's license, registration, or certificate of authority to act as a DPO suspended or revoked by any governmental agency, or did any governmental agency initiate formal legal proceedings for said purpose? If so, attach a statement containing complete details.		
f	Has any governmental entity imposed fines or costs, other than normal filing fees or renewal fees, for activities arising from DPO operations? If yes, attach a statement containing complete details.		

Name of Discount Plan Organization (DPO):

**Annual Report of DPO to the Florida Office of Insurance Regulation
For Fiscal Year Ending _____**

g	Has the DPO either maintained a surety bond in its own name, or securities eligible for deposit with Collateral Management, in an amount not less than \$35,000?		
h	Are all advertisements, marketing materials, brochures, and discount cards used by marketers approved in writing for such use by the DPO?		
i	Does the DPO have an executed written agreement with each marketer prior to the marketer's marketing, promoting, selling, or distributing the DPO?		
j	Is the DPO monitoring the content of all its websites for compliance with s.636.210, s.636.212, and s.636.226 Florida Statutes?		
k	Did the DPO fail to pay any judgment rendered, if any, against it in any state within 60 days after the judgment became final? If so, attach a statement containing complete details.		
l	Was the DPO at any time unable to fully pay when due any debts, or to timely meet any other obligations: If so, attach a statement containing complete details.		
m	Was the DPO or any of its owners, officers, or directors, convicted of, or did it (or that person) enter a plea of guilty or nolo contendere to a felony in any state without regard to whether adjudication was withheld? If so, attach a statement containing complete details.		

		Florida
n	For the year covered by this report, what was the total amount of revenue collected for Florida DPO business?	\$
o	How many residents of Florida are members of the DPO?	
p	List the internet websites used by the DPO and its marketers.	

Name of Discount Plan Organization (DPO):

Annual Report of DPO to the Florida Office of Insurance Regulation
For Fiscal Year Ending _____

CHECK LIST

Please indicate by checking the boxes that each action has been taken

- This Report has been completed in its entirety with all schedules.
- Audited CPA financial statements and Opinion Letter are attached.
- Separate responses, cross-referenced to the question, are attached where appropriate.
- All financial statements and schedules are mathematically correct.
- If required, biographical statements, background investigative reports, and fingerprint cards
- Evidence of payment of license renewal fee.
- Requests for clarification may be sent electronically to the e-mail address below.

The person to contact regarding any information contained in this report is:

(name & position / title)

(address)

(city, state, zip)

(____ - ____ - ____) ____ - ____ - ____ EXT: ____ - ____ - ____
(area code - telephone number - extension)

(____ - ____ - ____) ____ - ____ - ____
(area code - fax number)

(e-mail, if applicable)



**Office of Insurance Regulation
Life & Health Financial Oversight**

REMITTANCE FORM

Detach and separately forward this page prior to the due date of the required license renewal with your payment to the address below.

Name of Discount Plan Organization	
Street address	
City, State, Zip	
Federal Employer Identification Number	__ __ -- __ __ __ __ __ __ __ __
Florida Company Code	__ __ __ __ __
Renewal Date of License	_____ 20 __ __

ATTACH CHECK FOR \$50.00 HERE.

MAKE CHECK PAYABLE TO
DEPARTMENT OF FINANCIAL SERVICES

MAIL PAYMENT & THIS PAGE TO:

DEPARTMENT OF FINANCIAL SERVICES
REVENUE PROCESSING SECTION
P. O. BOX 6100
TALLAHASSEE, FLORIDA 32314-6100

FOR OFFICE OF INSURANCE REGULATION USE ONLY

AMOUNT	TYPE/CLASS	FEE	FUND ACCOUNT
\$50.00	1300	L	Renewal License Fee



Florida Office of Insurance Regulation

**ANNUAL REPORT
CONTRACTS ISSUED
& OUTSTANDING**

**MANAGED
CARE
COMPANY:** _____

YEAR ENDING: _____

**Number of health contracts issued and outstanding and number terminated.
[HMOs-641.26(1)(d), F.S.; PHCs-641.41(1)(c), F.S.; PLHSOs-636.043(2)(c), F.S.]**

Group subscriber contracts issued and outstanding

Individual subscriber contracts issued and outstanding

Group subscriber contracts terminated

Individual subscriber contracts terminated



Florida Office of Insurance Regulation

**ANNUAL REPORT
DAMAGE CLAIMS &
MEDICAL INJURY**

**MANAGED
CARE
COMPANY:** _____

YEAR ENDING: _____

**The number and amount of damage claims for medical injury initiated against the health entity and any providers engaged by it during the reporting year.
[HMOs-641.26(1)(e), F.S.; PHCs-641.41(1)(e); PLHSOs 636.043(2)(d)]**

Number of Claims _____

Total Dollar Value of Claims _____

Number of Claims Without Legal Process _____

Number of Claims Disposed (Settled, or Otherwise Discharged) _____

SERVICE OF PROCESS CONSENT & AGREEMENT

(Please type or print all information clearly)

Original Designation Insurer Name Change Merger/ Acquisition Update Delivery Information

Insurer or Company Name: _____

Previous Name (If applicable): - - - - -

Home Office Address: _____

City, State, Zip _____

_____ FEI# FL Company Code Telephone#

Know all men by these present, that the insurer or other entity named above is subject to the statutory agent for service of process provisions of the Florida Insurance Code duly organized and existing under and by virtue of the laws of the state of domicile.

Said entity does hereby agree and consent that actions may be commenced against it in any court having jurisdiction in any county in the State of Florida, in which a cause of action may arise, or in which the plaintiff may reside, by the service of process upon the Chief Financial Officer of the State of Florida. Said entity also hereby stipulates and agrees that any and all process so served shall be taken and held in all Courts to be as valid and binding upon this insurer or other entity as if personal service had been made upon the President or Secretary, or any other duly authorized and accredited officer thereof

The undersigned hereby further agrees and stipulates that this agreement is and shall remain irrevocable, so long as there is liability, under any policy, claim or cause of action within this state, either fixed or contingent. Said insurer or other entity does hereby designate the following as the name and address of the person to whom all process is to be forwarded when process is served upon said Chief Financial Officer of the State of Florida on behalf of the above named insurer or entity, **In the event of a change in the name of the insurer or the designation of the person to whom process is to be forwarded, whether it be name, address, and/or phone or fax numbers, the insurer or company shall immediately file a new agreement form with the Chief Financial Officer of the State of Florida at the address shown at the bottom of this page.**

Designated Person to receive process: _____

E-Mail Address: _____
Phone#: _____ **Fax#:** _____

Mailing Address: _____

Street Address: _____

Signature: _____
I hereby consent and agree to be the person to whom process served upon the Chief Financial Officer of the State of Florida for said entity, may be forwarded.

In Witness Whereof, we, the President or Chief Executive Officer and Secretary of said insurer or other entity, being duly authorized by the Board of Directors or governing body of this entity to execute this document, have hereunto set our hands and affixed the seal of said insurer or other entity on this the _____ day of _____, AD. _____.

President or CEO's Signature

President or CEO's Name (Typed or Printed)

Secretary's Signature

Secretary's Name (Typed or Printed)

Any signatures other than the President, CEO, or Secretary for the Company must be validated by the attachment of a resolution of the Board of Directors or Governing body of said company delegating the authority to sign for the company.

SEAL

690-203.210
690-191.107
OIR-C1-144
Rev 06/2004



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 Identigo by Idemia, at <https://fl.ibtfingerprint.com/>. For payment, processing, or appointment issues please contact the Identigo 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@floir.com. Fingerprinting must be performed by a technician within a law enforcement agency or other authorized entity. Most law enforcement agencies and many security companies provide civil applicant fingerprinting services.

NOTE: Please print your Payment Confirmation Number from the Identigo 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.



Florida Office of Insurance Regulation

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



Office of Insurance Regulation
Company Admissions

**APPLICATION FOR CERTIFICATE OF AUTHORITY
PREPAID LIMITED HEALTH SERVICE ORGANIZATION**

This package is designed to assist individuals in preparing the application with all the information required by statute and facilitate expeditious processing of the application by the Office. This package includes five (5) categories of information:

Section I	Application Fees and Form
Section II	Legal
Section III	Financial and Related Information
Section IV	Management
Section V	Forms and Rates

It is extremely important that the application be completed in its entirety in the format specified.

Please submit your package in a binder that has been two-hole punched at the top and place tabs at the bottom of the documents. (Example: the tab labeled II-1 would contain the certified Articles of Incorporation and all amendments).

THE COMPLETED CHECKLIST MUST BE RETURNED WITH THE APPLICATION PACKAGE!

It is recommended that, prior to filing the application, you schedule a pre-filing conference with the Managed Care Section to review any particular problems that our Office has encountered in the past. Although the pre-filing conference is not a statutory requirement, it has proven beneficial to both the applicant and the Office. To schedule a conference, please call (850) 413-2570.

Once the application is complete, mail it to:

Florida Office of Insurance Regulation
Applications Coordination Section
200 East Gaines Street, Larson Building
Tallahassee, Florida 32399-0332

**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 CERTIFICATE OF AUTHORITY
PREPAID LIMITED HEALTH SERVICE ORGANIZATION**

**INSTRUCTIONS
SECTION I - APPLICATION FEES AND FORM**

Section I-1 Application Fees

Applicants must pay a filing fee of \$500.00. The fee is due and payable at the time of filing the application for licensure.

Secure your check to the INVOICE (included in this package) and send to:

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

Place a copy of the INVOICE and a copy of the check with your application filing. This procedure will expedite the processing of your application and assure a timely recording of the fees.

Section I-2 Fingerprint Fees

Applicants are required to pay a fee for the processing of the fingerprint cards required in Section IV-3. The fingerprint cards along with the fees are due at the time the application is filed. A set of instructions for completing the fingerprint cards is included with this package.

Secure your check to the INVOICE (included in this package) and send to:

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

Place a copy of the INVOICE and a copy of the check along with the fingerprint cards in Section (I-2) of the application. This procedure will expedite the processing of your application and assure a timely recording of the fees.

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

On this form, list the lines of business by code (see enclosed classifications and code number form) that you intend to write in the State of Florida. **THE COMPANY MUST BE AUTHORIZED IN ITS STATE OF DOMICILE FOR THE LINES OF BUSINESS THAT ARE BEING REQUESTED.** When a Certificate of Authority is issued by the Office of Insurance Regulation, it will include only those lines listed on this form and addressed in the proformas in the Plan of Operations. This form must be under corporate seal and signed (original signatures) by both the President or Chief Executive Officer and the Secretary of the Company.

Form OIR-C1-1119
Rev 6/20
Rule 69O-203.020

**APPLICATION FOR CERTIFICATE OF AUTHORITY
PREPAID LIMITED HEALTH SERVICE ORGANIZATION**

SECTION II - LEGAL

Section II-1 Articles of Incorporation

Include in this section, the applicant's Articles of Incorporation and all amendments. These documents must be certified by the Florida Secretary of State. The certificate must be an original obtained from the Florida Secretary of State's office no earlier than six months prior to the date the application is filed. **SUBMIT AN ORIGINAL AND ONE COPY.**

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

Provide a Certificate of Status. This is a document issued by the Florida Secretary of State. The document certifies that the corporation is duly organized in this State and that all state taxes and fees have been paid. This certificate must be obtained from the Florida Secretary of State's office and be an original. [s. 636.005, F.S.]

If you have any questions concerning filing with the Secretary of State, please contact their Division of Corporations at (850) 245-6051.

Important note: The Secretary of State will issue a charter to a prepaid limited health service organization before the Office of Insurance Regulation completes its processing of an application for a certificate of authority. This charter authorizes the company to engage in any type of business except insurance. **Your company MAY NOT engage in the business of a prepaid limited health service organization in Florida until it has been issued a Certificate of Authority by the Director of Insurance Regulation.**

Section II-3 By-Laws, Constitution, or Rules and Regulations

Include two sets of the corporation's By-Laws, Constitution, and/or Rules and Regulations in this section. These documents must be accompanied by a Board Resolution signed and dated by the Secretary of the corporation, stating that the documents are a true and correct copy. **NO** other signatures will be accepted other than the Secretary's signature. **SUBMIT AN ORIGINAL AND ONE COPY.**

Section II-4 Certificate of Compliance (Foreign Applicants Only)

Provide a Certificate of Compliance. A Certificate of Compliance is a document issued by the public official having supervision of insurance in applicant's state of domicile showing that the company is duly organized and authorized to issue prepaid limited health service contracts therein and the kinds of contracts it is so authorized to transact. The certificate should be an original under seal by the insurer's state of domicile.

**FLORIDA DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
APPLICATION FOR CERTIFICATE OF AUTHORITY
PREPAID LIMITED HEALTH SERVICE ORGANIZATION**

SECTION III - FINANCIAL AND RELATED INFORMATION

Section III-1 Marketing and Growth

Submit a description of the proposed method of marketing, including the target groups, types of coverage to be offered, advertising media to be used, and contact representatives to be used. Also, submit a detailed marketing budget which reflects the proposed method of marketing for a three-year period. Include such items as compensation, local and out-of-town travel, equipment, printing and postage, advertising and public relations, expense accounts, meeting costs, and any applicable publications.

Section III-2 Advertising

Submit a full disclosure of the PLHSO's proposed advertising. All advertisements shall be available in English and shall include all printed and published material, descriptive literature and sales aids, sales talks and sales material, forms and pamphlets, illustrations, depictions and form letters, newspaper, radio, television, or direct mail. The full name and address of the PLHSO must be clearly contained in all advertisements. Each piece of advertising shall have a unique number or designation which will readily identify it from all other advertising.

Section III-3 Marketing Personnel

Submit a list of licensed health agents to be used initially in soliciting contracts or procuring applications.

Section III-4 Insurance

- A. Furnish evidence of adequate insurance coverage (copy of insurance policy) or an adequate plan for self-insurance to respond to claims for injuries arising out of the furnishing of limited health services.
 - (1) General liability.
 - (2) Medical malpractice or professional liability.

- B. Furnish evidence that a blanket fidelity bond in the amount of at least \$50,000. has been obtained (copy of bond). All employees handling the funds must be covered by the blanket fidelity bond. In lieu of the bond, the applicant may deposit with the Office cash or securities or other investments of the types set forth in section 636.042, Florida Statutes.

Section III-5 Financial

- A. A copy of the applicant's most recent financial statements audited by an independent certified public accountant.
- B. A copy of the applicant's financial plan, including a three-year projection of anticipated operating results, a statement of the sources of funding, and provisions for contingencies, for which projection all material assumptions shall be disclosed. Financial projections shall include:
 - (1) A balance sheet.
 - (2) An income statement.
 - (3) A cash flow analysis.
 - (4) A change in financial position.
- C. A description of how the applicant will comply with Section 636.046, Florida Statutes.
 - (1) Each PLHSO shall deposit with the Office cash or securities of the type eligible under Section 625.52, F.S., which shall have at all times a market value of \$50,000.
 - (2) If for any reason the market value of assets and securities of a PLHSO held on deposit in this state falls below the amount required, the organization shall promptly deposit other or additional assets or securities eligible for deposit sufficient to cure the deficiency.
- D. **Each PLHSO shall at all times maintain a minimum surplus in an amount which is the greater of \$150,000 or 10% of total liabilities.**
- E. Evidence that the applicant is financially responsible and may reasonably be expected to meet its obligations to enrollees and to prospective enrollees. This should include:
 - (1) Statement of the financial soundness of the applicant's arrangements for limited health services and the minimum standard rates, deductibles, co-payments, and other patient charges used in connection therewith.
 - (2) The adequacy of surplus, other sources of funding, and provisions for contingencies.
- F. Furnish a statement from a qualified independent actuary that the entity is actuarially sound.

Section III-6 Contractual

- A. A copy of the form of all contracts made or to be made between the applicant and any providers regarding the provision of limited health services to enrollees. Include a copy of each type of contract, with a signature page from each executed contract.
- B. A copy of the form of any contract made or to be made between the applicant and any person, corporation, partnership, or other entity for the performance on the applicant's behalf of any function including, but not limited to, marketing, administration, enrollment, investment management, and subcontracting for the provision of limited health services to enrollees.
- C. Copies of all relevant business leases, including rental of real property, equipment, etc. Include the anticipated cost for the life of the lease. If there are no business leases, please so indicate.

Section III-7 Enrollment

Describe the following assumptions underlying enrollment projections:

- A. A monthly projection of enrollment for a three-year period.
- B. Number of eligibles residing within the service area.
- C. Contract size assumptions (contract distribution and content).
- D. Penetration assumptions and rationale, including initial enrollments and renewals.
- E. Allowance for voluntary/involuntary disenrollment and group contract additions during the year.
- F. Date of break even (month, year) based on number of enrollments.

Section III-8 Certificate of Deposit (Foreign Insurers Only)

A Certificate of Deposit is a document issued by the public official having supervision of insurance in the applicant's state of domicile showing the amount and the composition of the deposit maintained by the insurer in another state. The certificate must be an original, sealed by the insurer's state or country of domicile.

**FLORIDA DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION
APPLICATION FOR CERTIFICATE OF AUTHORITY
PREPAID LIMITED HEALTH SERVICE ORGANIZATION
SECTION IV - MANAGEMENT**

ALL NAMES PROVIDED IN THIS SECTION SHOULD INCLUDE COMPLETE FIRST, MIDDLE AND LAST NAMES (no abbreviations).

Section IV-1 A list of the names (alphabetically), addresses, and official positions of the individuals who are responsible for conducting the applicant's affairs, including but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the officers, contracted management company personnel, and any person or entity owning or having the right to acquire ten percent or more of the voting securities of the applicant. Such persons shall fully disclose to the Office and to the directors the extent and nature of any contracts or arrangements between them and the PLHSO, including any possible conflicts of interest.

Section IV-2 A list of the owners of the PLHSO, including the extent of the ownership interest of each person or entity and an organizational chart depicting all levels of ownership, including all subsidiaries and parent organizations along with all affiliated companies and corresponding percentages of ownership.

Section IV-3 Biographical Statement and Affidavits, are to be submitted for all officers, directors, managers, and administrators of the PLHSO and all persons controlling and/or owning 10% or more of the ownership interest of the PLHSO. Be sure to include the management positions such as the executive director, medical director, finance director, and marketing director.

A Biographical Statement and Affidavit form (Office of Insurance Regulation Official Form Only) is included in this application package for you to duplicate and use in order to complete this section. All questions must be answered and all "yes" answers must be accompanied by an explanation. Each Biographical Statement and Affidavit must contain an original signature of the principal and an original notary seal. **Please file an original in the order of the list from Section IV-1. Do not retype the DOI Official Biographical Statement and Affidavit form. Retyped forms will not be accepted.**

The requirements for the affiant's social security as part of the Biographical Affidavit is mandatory. However, pursuant to sections 119.0721(1) and (8), Florida Statutes, social security numbers collected by an agency are confidential and exempt from section 119.07(1), Florida Statutes, and section 24(a), Art. I of the State Constitution and must be segregated on a separate page. Therefore, instead of including the SSN on page 1 of the Biographical affidavit, please include the affiant's name and social security on a separate page and attach it to the Biographical Affidavit. Also please stamp CONFIDENTIAL at the top and bottom of the separate page.

Section 119.0721(8), Florida Statutes, gives authority for an agency to collect social security numbers if imperative for the performance of that agency's duties and responsibilities as prescribed by law. Limited collection of social security numbers is imperative for the Office of Insurance Regulation. The duties of the Office of Insurance Regulation in background investigation are extensive in order to insure that the owners, management, officers, and directors of any insurer are competent and trustworthy, possess financial standing and business experience, and have not been found guilty of, or not pleaded guilty or nolo contendere to, any felony or crime punishable by imprisonment of one year.

Section IV-4 An Authority for Release of Information Form must be completed for each person listed in Section IV-3. Each Authority for Release form must contain an original signature of the principal and an original notary seal. **Please file an original of each Authority for Release of Information form in the order of the list provided in Section IV-1.**

Section IV-5 An Investigative Background Report must be provided for each person listed in Section IV-3. These reports must be mailed directly to the Office from the reporting entity. Because the reports are to be paid for by the applicant, please arrange for the billing to be sent by the investigative reporting firm to your accounting office. Instructions for providing these reports are enclosed. If using another reporting entity, please contact that company for instructions.

Evidence indicating that the reports have been ordered for all officers, directors, and trustees must be submitted by the applicant. Acceptable evidence includes a copy of the cancelled check issued to the investigative firm in payment for the reports and a copy of the letter of transmittal to the investigative firm with proof of mailing. The evidence should be dated no less than four (4) weeks prior to the date of the application.

Section IV-6 Fingerprint cards must be completed for each person listed in Section IV-3. The fingerprint cards along with the fees are due at the time the application is filed. **No cards other than those furnished by the Office will be accepted.** These cards must be completed at a law enforcement or similar type agency and returned to this Office for processing. A set of instructions for completing the fingerprint cards is included with this package.

PLEASE NOTE: Information which has been entered on the cards may not be altered in any way, i.e., erased, covered with correction fluid, marked out, etc. In addition, cards may not be folded, stapled, torn or marred in any way.

Section IV-7 A statement generally describing the applicant, its facilities and personnel, and the limited health service to be offered.

Section IV-8 A description of the subscriber complaint procedures to be established and maintained as required under Section 636.038, Florida Statutes.

**APPLICATION FOR CERTIFICATE OF AUTHORITY
PREPAID LIMITED HEALTH SERVICE ORGANIZATION
SECTION V - FORMS AND RATES**

NOTE: THE COMPANY IS CAUTIONED NOT TO WRITE BUSINESS USING UNAPPROVED FORMS OR RATES.

Section V-1 Forms

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

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

Section V-2 Rates

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

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

**APPLICATION FOR CERTIFICATE OF AUTHORITY
PREPAID LIMITED HEALTH SERVICE ORGANIZATION**

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

Company Name: _____

<u>Item #</u>	<u>Completion Check List</u>
1. Insurer application fees paid	<input type="checkbox"/>
(a) Copy of invoice included (Official Form).....	<input type="checkbox"/>
(b) Copy of check	<input type="checkbox"/>
(c) Placed in Section I	<input type="checkbox"/>
(d) Originals mailed to Bureau of Financial Services.....	<input type="checkbox"/>
2. Fingerprint fees paid.....	<input type="checkbox"/>
(a) Copy of invoice included	<input type="checkbox"/>
(b) Copy of check	<input type="checkbox"/>
3. Application for Certificate of Authority (Official Form)	<input type="checkbox"/>
(a) All blanks completed	<input type="checkbox"/>
(b) Sealed by corporation	<input type="checkbox"/>
(c) Signed by President or other authorized officer (original signature)	<input type="checkbox"/>
(d) Lines of business listed by codes	<input type="checkbox"/>

**APPLICATION FOR CERTIFICATE OF AUTHORITY
PREPAID LIMITED HEALTH SERVICE ORGANIZATION**

SECTION II - LEGAL

Company Name: _____

<u>Item #</u>	<u>Completion Check List</u>
1. Articles of Incorporation and all amendments.....	<input type="checkbox"/>
(a) Original certification by Florida Secretary of State	<input type="checkbox"/>
(b) Articles with all amendments attached	<input type="checkbox"/>
(c) Original and one copy	<input type="checkbox"/>
2. Certificate of Status from Florida Secretary of State (original document)	<input type="checkbox"/>
(a) Good standing indicated	<input type="checkbox"/>
(b) Sealed by state	<input type="checkbox"/>
(c) Signed by proper public official	<input type="checkbox"/>
(d) Original and one copy	<input type="checkbox"/>
2. Corporate By-Laws, Rules and Regulations, and/or Constitution	<input type="checkbox"/>
(a) Signed and dated by corporation secretary	<input type="checkbox"/>
(b) Sealed by corporation	<input type="checkbox"/>
(c) Original and one copy	<input type="checkbox"/>
(d) Board Resolution	<input type="checkbox"/>

**Section II - Legal
Required Filing and Check List**

<u>Item #</u>		<u>Completion Check List</u>
4.	Certificate of Compliance From State or County of domicile	<input type="checkbox"/>
	(a) Original Certification from State of domicile	<input type="checkbox"/>
	(b) Form indicates lines of business the company is authorized to transact	<input type="checkbox"/>

**APPLICATION FOR CERTIFICATE OF AUTHORITY
PREPAID LIMITED HEALTH SERVICE ORGANIZATION**

SECTION III - FINANCIAL AND RELATED INFORMATION

Company Name: _____

<u>Item #</u>	<u>Completion Check List</u>
1. Marketing and growth	<input type="checkbox"/>
(a) Description of marketing methods	<input type="checkbox"/>
(b) A detailed marketing budget	<input type="checkbox"/>
(c) List of persons employed to solicit contracts or procure applications.....	<input type="checkbox"/>
2. Advertising.....	<input type="checkbox"/>
(a) Include all printed and published material	<input type="checkbox"/>
(b) Sales talks, radio, TV, etc.	<input type="checkbox"/>
(c) Full name and address clearly shown	<input type="checkbox"/>
(d) Unique number or designation on each form.	<input type="checkbox"/>
3. Marketing personnel.....	<input type="checkbox"/>
(a) Submit a list of agents to be used initially.....	<input type="checkbox"/>
4. Insurance	<input type="checkbox"/>
(a) Current general liability policy or plan for self-insurance.	<input type="checkbox"/>
(b) Current medical malpractice policy or plan for self-insurance	<input type="checkbox"/>

**Section III - Financial and Related Information
Required Filing and Check List**

Item #	Completion Check List
5. Financial	<input type="checkbox"/>
A. Current audited financial statements	<input type="checkbox"/>
B. Financial plan and 3 yr. projections	<input type="checkbox"/>
Anticipated operating results.....	<input type="checkbox"/>
Statement of sources of funding	<input type="checkbox"/>
Provisions for contingencies	<input type="checkbox"/>
(1) A balance sheet.....	<input type="checkbox"/>
(2) An income statement.....	<input type="checkbox"/>
(3) A cash flow analysis	<input type="checkbox"/>
(4) A change in financial position	<input type="checkbox"/>
C. Evidence of compliance with Section III-5C 1&2.....	<input type="checkbox"/>
D. Compliance with minimum surplus requirement	<input type="checkbox"/>
E. Statement of soundness of the PLHSO	<input type="checkbox"/>
6. Contractual Documents	<input type="checkbox"/>
(a) Provider contract form and signature pages	<input type="checkbox"/>
(b) Other forms of contracts	<input type="checkbox"/>
(c) All relevant business leases	<input type="checkbox"/>
7. Complete enrollment information.....	<input type="checkbox"/>
(a) Sections A through F addressed	<input type="checkbox"/>

**Section III - Financial and Related Information
Required Filing and Check List**

Item #	Completion Check List
8. Certificate of Deposit	<input type="checkbox"/>
(a) Original document provided.....	<input type="checkbox"/>
(b) Original seal affixed by state of domicile	<input type="checkbox"/>

**APPLICATION FOR CERTIFICATION OF AUTHORITY
PREPAID LIMITED HEALTH SERVICE ORGANIZATION**

SECTION IV - MANAGEMENT

Company Name: _____

Item #	Completion Check List
1. Alphabetical listing of officers, directors, trustees, etc.....	<input type="checkbox"/>
(a) Separate listing of all officers and directors for the corporation	<input type="checkbox"/>
(b) Separate listing of trustees and others	<input type="checkbox"/>
(c) Full names listed	<input type="checkbox"/>
(d) Titles listed	<input type="checkbox"/>
2. A list of the owners of the PLHSO	<input type="checkbox"/>
(a) Extent of ownership interest of each person or entity	<input type="checkbox"/>
(b) Organizational chart showing all levels of ownership.....	<input type="checkbox"/>
3. Biographical affidavits for each individual listed in Section IV-3 (Official Form).....	<input type="checkbox"/>
For each biographical affidavit	
(a) All blanks completed.....	<input type="checkbox"/>
(b) "Yes" answers explained	<input type="checkbox"/>
(c) Contains original signature	<input type="checkbox"/>
(d) Notarized (original).....	<input type="checkbox"/>
(e) Submitted original of each affidavit.....	<input type="checkbox"/>

**Section IV - Management
Required Filing and Check List**

Item #	Completion Check List
4. Authority for Release of Information Forms for each individual listed in Section IV-3 (Official Form)	<input type="checkbox"/>
(a) Release form contains original signature	<input type="checkbox"/>
(b) Each release form is Notarized (original)	<input type="checkbox"/>
(c) Submitted original of each release form	<input type="checkbox"/>
5. Investigative Background Report for each individual listed in Section IV-3	<input type="checkbox"/>
(a) Investigative reporting firm contacted.....	<input type="checkbox"/>
(b) Full names given to investigative reporting firm for all individuals listed in Section IV-3	<input type="checkbox"/>
(c) Arrangements made for reports to be sent directly to this Office.....	<input type="checkbox"/>
(d) Evidence indicating report has been ordered for all officers, directors and trustees, dated no less than 4 weeks prior to date of application (cancelled check or letter of transmittal).....	<input type="checkbox"/>
6. Fingerprint cards enclosed for each person listed Section IV-3.....	<input type="checkbox"/>
(a) Contains original signature	<input type="checkbox"/>
(b) Card furnished by Office of Insurance Regulation.....	<input type="checkbox"/>
(c) No erasures or alterations on cards	<input type="checkbox"/>
(d) All blanks filled in.....	<input type="checkbox"/>

**Section IV - Management
Required Filing and Check List**

Item #	Completion Check List
7. A statement describing the applicant, facilities and personnel, and service to be offered	<input type="checkbox"/>
8. Description of subscriber complaint procedures.....	<input type="checkbox"/>

**APPLICATION FOR CERTIFICATE OF AUTHORITY
PREPAID LIMITED HEALTH SERVICE ORGANIZATION**

SECTION V - FORMS AND RATES

Company Name: _____

Item #	Completion Check List
1. Forms	<input type="checkbox"/>
(a) 3 copies of each.....	<input type="checkbox"/>
(b) Identified by unique form number	<input type="checkbox"/>
2. Rates	<input type="checkbox"/>
(a) 3 copies of each filing	<input type="checkbox"/>
(b) Opinion from qualified actuary or employee.....	<input type="checkbox"/>
(c) Statement of actuarial soundness	<input type="checkbox"/>

**APPLICATION FOR CERTIFICATE OF AUTHORITY FORM
PREPAID LIMITED HEALTH SERVICE ORGANIZATION**

Pursuant to Chapter 636, Florida Statutes, application is hereby submitted to form and operate a Prepaid Limited Health Service Organization.

Proposed name of Prepaid Limited Health Service Organization:

NAME: _____

ADDRESS: _____

CITY: _____ ZIP CODE: _____

FEDERAL IDENTIFICATION NUMBER: _____

PHONE: _____

CONTACT PERSON: _____

ATTORNEY OR PRINCIPAL FILING THIS APPLICATION:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

In order to qualify as a Prepaid Limited Health Service Organization (PLHSO), an entity shall:

- (1) Provide or arrange for, or provide access to, the provision of a limited health service to enrollees through an exclusive panel of providers. This **MAY** include ambulance services, dental care services, vision care services, mental health services, substance abuse services, chiropractic services, podiatric care services **OR** pharmaceutical services.

NOTE: Limited health services shall not include inpatient, hospital surgical services, or emergency services, except as such services are provided incident to the limited health services.

- (2) Provide, either directly or through arrangement with other persons, limited health care services to persons enrolled with such organization, on a prepaid per capita or prepaid aggregate fixed sum basis; and
- (3) Provide, either directly or through arrangements with other persons, limited health care services to subscribers through a closed panel of providers.

APPLICATION CERTIFICATION

The undersigned states that they are an officer having personal knowledge of the application submitted to the Florida Office of Insurance Regulation in connection with the intention of _____ (“Applicant”) to apply to operate as a _____ in this state; that they have read all of the responses, information, exhibits, and documents submitted with, and in support of, this application; and that the submissions are true, correct, and complete to the best of their knowledge. The undersigned further represent that they have the authority to bind the Applicant, and that by their signatures on the instrument, the Applicant has executed the instrument.

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

(Corporate Seal)

By: _____

Print Name: _____

Title: _____

Date: _____

STATE OF _____

COUNTY OF _____

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

or online notarization, this ____ day of _____ 20__, by _____
(name of person)

as _____ for _____.

(type of authority; e.g., officer, trustee, attorney in fact)

(company name)

(Signature of the Notary)

(Print, Type or Stamp Commissioned Name of Notary)

Personally Known _____ OR Produced Identification _____

Type of Identification Produced _____

My Commission Expires: _____

**Application for Certificate of Authority
Prepaid Limited Health Services Organizations
Lines of Business Codes**

Lines of Business	Code Numbers
Dental Care Services	451
Ambulance Services	700
Vision Care Services	712
Pharmaceutical Service	716
Mental Health Service	781
Substance Abuse Services	782
Chiropractic Services	783
Podiatric Care Services	784

Applicant Company Name: _____

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.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names). _____

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE. 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 (MM/YY)</u>	<u>Degree Obtained</u>

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

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

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

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

6. List of memberships in professional societies and associations:

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

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

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

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: _____

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.

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,

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

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. _____

- 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?

Applicant Company Name: _____

NAIC No. _____

FEIN: _____

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: _____

NAIC No. _____

FEIN: _____

**BIOGRAPHICAL AFFIDAVIT
Supplemental Personal Information**

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. 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.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

1. Affiant's Full Name (Initials Not Acceptable): First:_____ Middle:_____ Last:_____ **IF ANSWER IS "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 Date(s) Used (MM/YY)</u>	<u>Name(s) Specify: First, Middle or Last Name</u>	<u>Reason (If NONE, indicate such)</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

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

Applicant Company Name: _____

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>
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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: _____

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: _____

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: _____

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: _____

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: _____

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: _____

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.



Office of Insurance Regulation
Company Admissions

**APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)**

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

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

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

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

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

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

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

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

**APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)**

Pursuant to Section 636.Part II, Florida Statutes, in order to do business as a Discount Plan Organization (DPO), an entity must:

- A. Be a corporation, a limited liability company, or a limited partnership, incorporated, organized, formed, or registered under the laws of this state or authorized to transact business in this state in accordance with Chapter 605, Part I of Chapter 607, Chapter 617, Chapter 620, or Chapter 865, F.S., and must be licensed by the Office as a discount plan organization or be licensed by the Office pursuant to Chapter 624, Part I of Chapter 636, or Chapter 641, F.S.
[s., 636.204(1), F.S.];

- B. Be an entity, which in exchange for fees, dues, charges, or other consideration, provides access for plan members to providers of medical services and the right to receive medical services from those providers at a discount. [s.636.202(2), F.S.];

**APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)**

**INSTRUCTIONS
SECTION I - APPLICATION FEES AND FORM**

Section I-1 Application Fee

The application filing fee is \$50.00. The initial fee is due and payable at the time of filing the application for licensure. [s.636.204(2)(l) and s.636.204(5), F.S.]

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 Fingerprint Processing Fees

Applicants are required to prepay electronically for the processing of the fingerprint cards required in Section IV-4. Please see Form OIR-C1-938 for instructions.

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

Section I-3 Application for License (Official Form included with this package)

This form must be sworn to by an officer or authorized representative of the applicant.

SECTION II-LEGAL

Section II-1 Articles of Incorporation

Include in this section the applicant's Articles of Incorporation or other organizing documents, including all amendments. The required filings must be recently certified by the official public records custodian in the applicant's state of domicile. The certification letter must be an original. [s.636.204(2)(a), F.S.]

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

Provide a Certificate of Status document issued by the Florida Secretary of State which certifies that the applicant is authorized in this State and that all state taxes and fees

**APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)**

have been paid. This certificate must be obtained from the Florida Secretary of State's office and be an original. [s.636.204(1), F.S.]

If you have any questions concerning filing with the Secretary of State, please contact the Division of Corporations at (850) 245-6051 or see <http://www.sunbiz.org/>.

Important note: The Secretary of State will issue a charter to a discount plan organization before the Office completes its processing of an application for a license. This charter authorizes the company to engage in any type of business except insurance or discount plans, or other regulated business.

Your company MAY NOT engage in the business of a discount plan in Florida until it has been issued a license by the Commissioner of the Office.

Section II-3 By-Laws, Constitution, or Rules and Regulations

Include a copy of the applicant's By-Laws, Constitution, and/or Rules and Regulations in this section. The bylaws must be signed, and recently dated by the Secretary of the company. No signature other than the Secretary's will be accepted. [s. 636.204(2)(b), F.S.]

Section II-4 Certificate of Compliance (Foreign Applicants Only)

If applicable, provide a Certificate of Compliance issued by the public official having supervision in applicant's state of domicile showing that the company is organized and authorized to issue contracts and the kinds of contracts it is authorized to transact. The certificate should be an original under seal by the organization's state of domicile. If not applicable, please state this in the application.

Section II-5 Service of Process Form

[s.636.234, 624.422 and 624.423 F.S.]

Provide an executed Service of Process Consent and Agreement form (official form included in this package) under corporate seal and signed by the president or chief executive officer and secretary.

**APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)**

SECTION III - FINANCIAL AND RELATED INFORMATION

Section III-1 Marketing and Growth

Submit a description of the proposed method of marketing, including the target groups, types of discounts to be offered, and advertising media to be used.
[s. 636.204(2)(j), F.S.]

Section III-2 Advertising

Provide a description of the procedures in place for the DPO to approve advertising, prior to use, pursuant to Section 636.228, Florida Statutes.

Section III-3 Website

Prior to licensure by the Office, each DPO must establish an Internet website that conforms to the requirements of Section 636.226, Florida Statutes. [s. 636.204(4)] This website should also comply with the disclosures required in s. 636.212, F.S. and should not include any prohibitions listed in s. 636.210, F.S.

Provide the address of the website that complies with these statutes.

Section III-4 Financial

A. Submit a copy of the applicant's most recent financial statements audited by an independent certified public accountant [s.636.204,(2)(i), F.S.], and provide the date of the company's fiscal year end.

B. Each DPO must at all times maintain a net worth of at least \$150,000.
[s.636.220(1), F.S.]

The OFFICE may not issue a license unless the DPO has a net worth of at least \$150,000.
[s.636.220(2), F.S.]

C. Documentation that the applicant has complied with the surety bond or security deposit requirements [636.236(1), Florida Statutes]. For security deposits, contact the Bureau of Collateral Management at (850) 413-3167.

(1) Each DPO must maintain in force (unless deposit is placed in lieu of the bond) a surety bond in its own name in an amount not less than \$35,000 to be used at the discretion of the Office to protect the financial interest of members who may be adversely affected by the insolvency of a DPO. The bond must be issued by an insurance company that is licensed to do business in this state.

**APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)**

- (2) In lieu of #1 above, each DPO shall deposit with the Bureau of Collateral Management cash or securities of the type eligible under Section 625.52, Florida Statutes, which shall have at all times a market value of \$35,000.
- (3) If for any reason the market value of assets and securities of DPO held on deposit in this state falls below the amount required, the organization shall promptly deposit other or additional assets or securities eligible for deposit sufficient to cure the deficiency.

Section III-5 Contractual

- A. A copy of the form of all contracts made or to be made between the applicant and any providers or provider networks regarding the provision of medical services to members. [s. 636.204(2)(f), F.S.]
- B. A copy of the form of any contract made or to be made between the applicant and any person, corporation, partnership, or other entity for the performance on the applicant's behalf of any function including, but not limited to, marketing, administration, enrollment, investment management, and subcontracting for the provision of health services to members. [s. 636.204(2)(h), F. S.]
- C. A copy of the form of any contract made or arrangement to be made between the applicant and any person listed in the Management Section (Section IV) of this application as individuals who are responsible for conducting the applicant's affairs, including but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the officers, contracted management company personnel, and any person or entity owning or having the right to acquire 10% or more voting securities of the applicant. [s. 636.204(2)(c) and (g), F.S.]

Section III-6 A statement generally describing the applicant, its facilities and personnel, and the medical services to be offered. [s. 636.204(2)(e), F.S.]

Section III-7 A description of the subscriber complaint procedures to be established and maintained. [s. 636.204,(2)(k), F.S.]

**APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)**

SECTION IV - MANAGEMENT

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

Section IV-1 List of All Officers, Directors, and Shareholders [s.636.204(2)(c) F.S.]

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

Section IV-2 Biographical Affidavits for Officers, Directors and Shareholders [s.636.204(2)(d),F.S.]

Provide a Biographical Affidavit (Form OIR-C1-1423) for each officer, director, any person having direct or indirect control of the organization, including but not limited to contracted management company personnel and shareholder listed in Section IV-1 except for those companies in the organizational structure between the immediate parent and the ultimate parent. All questions must be answered. All "Yes" answers must be explained.

Each biographical affidavit must contain an original signature and original notary seal.

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 SSN on the Biographical Affidavit, please include the affiant's name and social security number on a separate page and attach it to the Biographical Affidavit. Also please 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

**APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)**

responsibilities as prescribed by law. Limited collection of social security numbers is imperative for the Office. The duties of the Office 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.

Section IV-3 Investigative Background Reports [636.204(2)(d) F.S.]

A Background Investigative Report must be provided for each person listed in Section IV-1 above except for those companies in the organizational structure between the immediate parent and the ultimate parent. Background reports must be submitted by the selected background investigator vendor prior to or contemporaneously with the application filing. Please refer to form OIR-C1-905 REV 02/15 for instructions.

Section IV-4 Fingerprint Cards

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

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

**APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)**

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

Company Name: _____

<u>Item #</u>	<u>Completion Check List</u>
1. Insurer application fees paid.....	<input type="checkbox"/>
(a) Copy of invoice included (Official Form).....	<input type="checkbox"/>
(b) Copy of check.....	<input type="checkbox"/>
(c) Originals mailed to Revenue Processing Section.....	<input type="checkbox"/>
2. Fingerprint fee paid electronically.....	<input type="checkbox"/>
a. Copy of on-line payment confirmation.....	<input type="checkbox"/>
3. Application for License (Official Form).....	<input type="checkbox"/>
(a) All blanks completed.....	<input type="checkbox"/>
(b) If applicable, sealed by corporation.....	<input type="checkbox"/>
(c) Signed by President or other authorized officer (original signature).....	<input type="checkbox"/>

**APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)**

SECTION II – LEGAL

Company Name: _____

<u>Item #</u>	<u>Completion Check List</u>
1. Articles of Incorporation or other organizing documents and all amendments attached with an original certification by the State of Domicile	<input type="checkbox"/>
2. Certificate of Status from Florida Secretary of State (original document)	<input type="checkbox"/>
(a) Good standing indicated.....	<input type="checkbox"/>
(b) Sealed by state.....	<input type="checkbox"/>
(c) Signed by proper public official.....	<input type="checkbox"/>
(d) Original.....	<input type="checkbox"/>
3. Corporate By-Laws, Rules and Regulations, and/or Constitution	<input type="checkbox"/>
(a) Signed and dated by applicant's secretary.....	<input type="checkbox"/>
4. Certificate of Compliance from State of domicile.....	<input type="checkbox"/>
(a) Original Certification from State of domicile.....	<input type="checkbox"/>
(b) Form indicates the kinds of contracts the company is authorized to transact.....	<input type="checkbox"/>
(c) Not applicable.....	<input type="checkbox"/>
5. Service of Process Form.....	<input type="checkbox"/>

**APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)**

SECTION III - FINANCIAL AND RELATED INFORMATION

Company Name: _____

<u>Item #</u>	<u>Completion Check List</u>
1. Marketing and growth	<input type="checkbox"/>
(a) Description of marketing methods.....	<input type="checkbox"/>
2. Advertising.....	<input type="checkbox"/>
(a) Include a description of advertising procedures.....	<input type="checkbox"/>
3. Provide website address.....	<input type="checkbox"/>
4. Financial	<input type="checkbox"/>
A. Current audited financial statements & fiscal year end date...	<input type="checkbox"/>
B. Compliance with minimum surplus requirement.....	<input type="checkbox"/>
C. Original document evidencing compliance with surety bond requirement or security deposit requirement as explained in S.III-4C 1&2.....	<input type="checkbox"/>
5. Contractual Documents	<input type="checkbox"/>
(a) Provider contract form	<input type="checkbox"/>
(b) Other forms of contracts per s.636.204(2)(h), F.S.....	<input type="checkbox"/>
(c) Other forms of contracts per s.636.204(2)(c) and (g), F.S.....	<input type="checkbox"/>
6. Statement describing facilities, personnel, and medical services...	<input type="checkbox"/>
7. Description of subscriber complaint procedures.....	<input type="checkbox"/>

**APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)**

SECTION IV – MANAGEMENT

Note: This portion of the checklist is detailed in order to assist the applicant in ensuring all items are completed, and checklist item numbers will not correlate with item numbers in the Instructions.

<u>Item #</u>	<u>Completion Check List</u>
1. Listing of all officers, directors, and shareholders (including entities owning 10% or more of applicant (Form OIR-C1-1298)	<input type="checkbox"/>
2. Listing of all <u>immediate</u> parent(s) officers, directors, and shareholders (including entities) owning 10% or more of parent company's stock (Form OIR-C1-1298)	<input type="checkbox"/>
3. Listing of all <u>intermediary</u> parent(s) (between immediate parent(s) and ultimate parent(s)), officers and shareholders (including entities) owning 10% or more of parent company's stock (Form OIR-C1-1298). Note, do not complete Form OIR-C1-1423, (Biographical Affidavits) or order investigative reports or fingerprint cards.....	<input type="checkbox"/>
4. Listing of all <u>ultimate</u> parent(s) officers, directors, and shareholders (including entities) owning 10% or more of parent company's stock (Form OIR-C1-1298)	<input type="checkbox"/>
5. Organizational Chart including all entities within the ultimate parent company structure.....	<input type="checkbox"/>
6. Biographical Affidavits for company officers, directors, and shareholders (including entities) owning 10% or more of applicant (Form OIR-C1-1423)	<input type="checkbox"/>
As to each biographical:	
(a) All blanks completed.....	<input type="checkbox"/>
(b) Contains original signature	<input type="checkbox"/>
(c) Notarized (original)	<input type="checkbox"/>
(d) SSN on a separate page.....	<input type="checkbox"/>

**APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)**

**SECTION IV – MANAGEMENT
Required Filing and Check list**

7. Biographical Affidavits for immediate parent(s) officers, directors, and shareholders (including entities) owning 10% or more of parent Company's stock (Form OIR-C1-1423)
- As to each biographical:**
- (a) All blanks completed.....
- (b) Contains original signature.....
- (c) Notarized (original).....
- (d) SSN on a separate page.....
8. Biographical Affidavits for ultimate parent(s) officers, directors, and Shareholders (including entities) owning 10% or more of parent company's Stock (Form OIR-C1-1423)
- As to each biographical:**
- (a) All blanks completed.....
- (b) Contains original signature.....
- (c) Notarized (original).....
- (d) SSN on a separate page.....
9. Background investigative reports for company officers, directors, and shareholders (including entities) owning 10% or more of applicant.....
10. Background Investigative reports for immediate parent(s) officers, directors and shareholders (including entities) owning 10% or more of parent company's stock.....
11. Background Investigative reports for ultimate parent(s) officers, directors and shareholders (including entities) owning 10% or more of parent company's stock.....

**APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)**

Note: If fingerprints are digitally scanned, Items 12, 13 and 14 are not applicable.

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

As to each fingerprint card:

(a) Contains original signature.....

(b) Florida cards only.....

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

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

As to each fingerprint card:

(a) Contains original signature.....

(b) Florida cards only.....

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

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

(a) Contains original signature.....

(b) Florida cards only.....

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

**APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)**

CHECKLIST VERIFICATION

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

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

Dated _____
(Give full and exact name of applicant)

Signature of President, Secretary, or Treasurer

Printed Name

Printed Title

**APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)**

Pursuant to Chapter 636, Part II Florida Statutes, application is hereby submitted to form and operate a Discount Plan Organization.

In order to qualify as a Discount Plan Organization (DPO), an entity must:

- A. Be a corporation, a limited liability company, or a limited partnership, incorporated, organized, formed, or registered under the laws of this state or authorized to transact business in this state in accordance with Chapter 605, part I of Chapter 607, Chapter 617, Chapter 620, or Chapter 865, F.S., and must be licensed by the Office as a discount plan organization or be licensed by the Office pursuant to Chapter 624, Part I of Chapter 636, or Chapter 641, F.S. [s., 636.204(1), F.S.];
- B. Be an entity which, in exchange for fees, dues, charges, or other consideration, provides access for plan members to providers of medical services and the right to receive medical services from those providers at a discount. [s.636.202(2), F.S.];

Proposed name of Discount Plan Organization:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

FEDERAL IDENTIFICATION NUMBER: _____

PHONE: _____

CONTACT PERSON: _____

E-MAIL: _____ FAX: _____

ATTORNEY OR PRINCIPAL FILING THIS APPLICATION:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: _____ E-MAIL: _____ FAX: _____

**APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)**

APPLICATION CERTIFICATION

The undersigned states that they are an officer having personal knowledge of the application submitted to the Florida Office of Insurance Regulation in connection with the intention of _____ (“Applicant”) to apply to operate as a _____ in this state; that they have read all of the responses, information, exhibits, and documents submitted with, and in support of, this application; and that the submissions are true, correct, and complete to the best of their knowledge. The undersigned further represent that they have the authority to bind the Applicant, and that by their signatures on the instrument, the Applicant has executed the instrument.

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

(Corporate Seal)

By: _____

Print Name: _____

Title: _____

Date: _____

STATE OF _____

COUNTY OF _____

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

or online notarization, this ____ day of _____ 20__, by _____
(name of person)

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

(Signature of the Notary)

(Print, Type or Stamp Commissioned Name of Notary)

Personally Known _____ OR Produced Identification _____

Type of Identification Produced _____

My Commission Expires: _____

**APPLICATION FOR LICENSE
DISCOUNT PLAN ORGANIZATION (DPO)**

**INVOICE
PAYMENT OF APPLICATION FEE**

NAME OF COMPANY: _____

FEIN #: _____

ADDRESS: _____

CITY, STATE & ZIP CODE: _____

PHONE NUMBER: _____

ADDRESS (IF DIFFERENT FROM STREET ADDRESS)

(CITY)

(STATE)

(ZIP CODE)

E-MAIL ADDRESS: _____ FAX: _____

In reference to the recent submission by the above-referenced discount ~~medical~~ plan organization regarding its application to do business in Florida, it is necessary that you return this form with the proper payment as listed below.

PLEASE NOTE:

1. Send a check in the proper amount made payable to the Florida Department of Financial Services and mail check and invoice only to the Florida Department of Financial Services, Revenue Processing Section, P.O. Box 6100, Tallahassee, Florida 32314-6100.
2. Include a copy of the check and invoice with the application filing submitted electronically via iApply.

If you have any questions, please contact Applications Coordination at (850) 413-2575.

	<u>B/T</u>	<u>TY/CL</u>	<u>F/T</u>	<u>AMOUNT</u>
Filing Fee	C	1249F	F	\$ 50.00



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 %
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*Additional pages in like format may be attached as necessary