APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION

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

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

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

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

The completed application packet must be submitted to the Office at the following link:

https://www.floir.com/iportal

Any questions concerning this application packet may be directed to lhappcoord@floir.com.

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

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

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

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

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

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

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

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

INSTRUCTIONS

SECTION I - APPLICATION FEES

Section I-1 Application Fee & Deposit

a. Applicant must pay the application fee of $1,000 U.S. Dollars ("USD"), pursuant to Section 641.29(1), Florida Statutes. This fee is due when the application packet is filed and is not refundable.

b. In compliance with Section 641.227(1), Florida Statutes, Applicant must also submit a deposit for $10,000 USD for use in the Rehabilitation Administrative Expense Fund.

Section I-2 Assessment

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

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

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

Section I-3 Fingerprint Processing Fees

Applicants are required to pay a fee directly to the vendor for the processing of the fingerprint cards as required in Section IV-4.

Section I-4 Application Certification

Pursuant to Section 641.21(1), Florida Statutes, each HMO application must be verified by the oath of two officers of the corporation and notarized. Accordingly, Applicant should have **two copies of page 15** executed and submitted with its application.

SECTION II - LEGAL

Section II-1 Articles of Incorporation

Submit a copy of Applicant's Articles of Incorporation complete with all amendments and certified within the last year by the Florida Secretary of State.

Section II-2 Bylaws

Submit a copy of Applicant's Bylaws or equivalent document. This should be certified within the last year by Applicant's Secretary as a true and correct copy of the current document. Only the Secretary's signature will be accepted, unless Applicant does not have this position.

Section II-3 Florida Certificate of Status

Submit a Certificate of Status issued within the last year by the Florida Secretary of State.

Section II-4 Authorization Letter

Provide a letter of authorization for any person, other than Applicant's personnel, who is authorized to represent the Applicant before the Office in this matter. This letter should be dated within the last year.

Section II-5 Fictitious Name Filing

If the Applicant plans to utilize a fictitious name, provide documentation of Applicant's compliance with the fictitious name statutes of this state.

SECTION III - FINANCIAL AND RELATED INFORMATION

Section III-1 Insurance

a. Furnish evidence of adequate insurance coverage or an adequate plan for self-insurance to respond to claims for injuries arising from the provision of health care services. If not self-insured, submit executed copies of the following policies, with the Office listed on the policies for purposes of notification of any modification, cancellation, or termination of the policies:

i. General liability

ii. Medical malpractice or professional liability. The HMO must secure this coverage. The fact that the medical provider has this coverage does not release the HMO from the obligation to secure it. A binder for the policies along with a specimen copy of each policy can be submitted initially. Prior to licensure, executed copies of the policies must be submitted.

b. Furnish a photocopy of an executed fidelity bond in the minimum amount of $100,000 USD issued by a Florida authorized insurance carrier and covering all employees handling funds.

c. Describe how the HMO limits or proposes to limit its financial risk. If the HMO secures catastrophic or reinsurance coverage, it is required to submit copies of the applicable policy with the Office. Any reinsurance agreement must comply with Section 624.610, Florida Statutes, and Rule Chapter 69O-144, Florida Administrative Code.

NOTE: Describe any risk sharing arrangements with providers or any other parties. Reference by page number sections of any provider contracts which demonstrate the sharing of risk between the HMO and providers.

Section III-2 Financial Statements

a. Provide a copy of the most recent audited independent certified public accountant's report prepared on the basis of statutory accounting principles. If the applicant is a development stage company that has not begun operations, an audited balance sheet should be provided. The financial statements should reflect sufficient surplus to meet the requirements of Section 641.225, Florida Statutes.

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

Section III-3 Plan of Operations

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

If the HMO intends to market to small groups as defined by the Employee Health Care Access Act, s. 627.6699, Florida Statutes, please complete and submit the attached Small Employer Carrier's Application To Becomes A Risk Assuming Carrier Or A Reinsuring Carrier, As Required By Section 627.6699(9), Florida Statutes (Form OIR-B2-1093).

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

Section III-4 Marketing and Growth

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

Section III-5 Pro Forma Statements

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

Section III-6 Statement of Initial Cash

Submit a statement of the proposed initial cash and cash reserves summary, including loan receipts, loan repayments, stock sales, etc. Also, describe the sources and terms of the funding. In the case of guaranteeing organizations, as referenced in Section 641.225, Florida Statutes, submit audited financial statements, certified by an independent certified public accountant, prepared in accordance with generally accepted accounting principles, covering its two most current annual accounting periods.

Section III-7 History

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

Section III-8 Insolvency Protection

Provide the method in which the applicant will comply with the insolvency protection requirements of Section 641.285, Florida Statutes, including all relevant documentation necessary to meet the requirements. Each HMO must comply with the insolvency protection requirements of Florida law. This is accomplished through a deposit of $300,000 USD in accordance with Section 641.285, Florida Statutes..

Section III-9 Contingency Plans

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

Section III-10 Feasibility Study

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

The financial portion of the study shall be prepared in accordance with standards promulgated by the American Institute of Certified Public Accountants in its "Guide for

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

Section III-11 Contracts

a. A copy of each type of contract made, or to be made, between the applicant and any providers (i.e hospitals, physicians, physician groups) regarding the provision of health care services to enrollees. All such contracts shall comply with Section 641.315, Florida Statutes.

b. A copy of the form of any contract made or to be made between the applicant and senior management employment, as well as any person, corporation, partnership, or other entity for the performance on the applicant's behalf of any function including, but not limited to, marketing, administration, enrollment, investment management, and subcontracting for the provision of health care services to enrollees. All such contracts shall comply with Section 641.234, Florida Statutes and 641.315, F.S. if applicable.

Section III-12 Grievance Procedure

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

Section III-13 Bankruptcy Proceedings

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

A. An acknowledgment that a delinquency proceeding pursuant to Part I of Chapter 631 or supervision by the Office pursuant to s. 624.80-624.87, Florida Statutes, constitutes the sole and exclusive method for the liquidation, rehabilitation, reorganization, or conservation of a health maintenance organization.

B. A waiver of any right to file or be subject to a bankruptcy proceeding; and

C. An acknowledgment that the commencement of a bankruptcy proceeding either by or against a health maintenance organization shall, by operation of law, terminate the health maintenance organization's certificate of authority and vest in the Office for the use and benefit of the subscribers of the health maintenance organization the title to any deposits of the insurer held by the Office.

Section III-14 Health Care Provider Certificate

Submit documentation demonstrating that the entity has filed an application for a Health Care Provider Certificate to be issued by the Agency for Health Care Administration (AHCA) pursuant to Chapter 641, Part III, Florida Statutes. Documentation may be provided in the form of an acknowledgement from the Agency for Health Care that the application has been received by them.

NOTE: The Office will begin its review of an application for a Certificate of Authority any time after an organization has filed an application for the certificate with the Agency for Health Care Administration. The Office shall not issue a Certificate of Authority to any applicant, which does not possess a valid Health Care Provider Certificate. Once the Health Care Provider Certificate is issued, a copy must be provided to the Office of Insurance Regulation.

SECTION IV - MANAGEMENT

Section IV-1 List of All Officers, Directors, and Stockholders, etc

1. Using the Management Information Form (Form OIR-C1-2221), list the names, addresses, and official capacities with the organization of the persons who are to be responsible for the conduct of the affairs of the health maintenance organization, including all officers, directors, and owners of in excess of 5% of the common stock of the corporation, and contracted management company personnel. Such persons shall fully disclose to the office and the directors of the health maintenance organization the extent and nature of any contracts or arrangements between them and the health maintenance organization, including any possible conflicts of interest.

   Additionally, list any person having the right to acquire 10% or more of Applicant's voting securities, or any person otherwise having direct or indirect control of Applicant, or who influences or has the ability to influence the transaction of Applicant's business, up to and including Applicant's ultimate parent.

   A separate Management Information Form should be submitted for each entity. Forms should contain the First, Middle, and Last name of listed individuals. Please state if a middle name does not exist.

2. If Applicant is a subsidiary of a parent or holding company, provide a complete organization chart showing the relationship of all affiliated entities.

Section IV-2 Biographical Information Package

Each person listed in Section IV-1, must submit a complete Biographical Information Package.

The Biographical Information Package consists of the following forms:

- OIR-C1-1423, "Uniform Certificate of Authority Application (UCAA) Biographical Affidavit"
- OIR-C1-938, "Fingerprints and Social Security Number"
- OIR-C1-0500, "UCAA Biographical Affidavit Addendum Blank"
- OIR-C1-0501, "UCAA Biographical Affidavit Addendum Education"
- OIR-C1-0502, "UCAA Biographical Affidavit Addendum Employment"
- OIR-C1-0503, "UCAA Biographical Affidavit Addendum General"
- OIR-C1-0504, "UCAA Biographical Affidavit Addendum Licenses"
- OIR-C1-0505, "UCAA Biographical Affidavit Addendum Professional"
- OIR-C1-0506, "UCAA Biographical Affidavit Addendum Residence"
- OIR-C1-0507, "UCAA Biographical Affidavit Addendum Societies"
- OIR-C1-0509, "Uniform Certificate of Authority Application (UCAA) Biographical Affidavit Cover Letter Holding Company Structure"

Each person must complete forms OIR-C1-1423 and OIR-C1-938, as well as all additional forms that are applicable to that individual.

Each form must be signed, and form OIR-C1-1423 must be notarized.

All questions must be answered. All "Yes" answers must be explained.

Individuals who have previously submitted a Biographical Information Package to the Office may inquire with the Office to determine if the previous submission is recent enough to meet this requirement.

Section IV-3 Background Investigative Report

A background investigation report must be provided for each person required to provide a Biographical Information Package. These reports must be ordered from and submitted by a background investigation vendor directly to the Office at bkgrnd-inv@floir.com who has been approved for use by the National Association of Insurance Commissioners. Submission 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. The application will not be considered complete until all required

background investigation reports are received. Attach proof of payment confirming that all background reports have been ordered when submitting the application.

A list of approved vendors can be found at https://content.naic.org/industry-ucaa-third-party. The applicant is responsible for the reports and for handling billing arrangements with the selected vendor. Questions regarding this process may be directed to lhappcoord@floir.com.

Section IV-4 Fingerprinting and Social Security Number Submission

Each person submitting a Biographical Information Package under Section IV-2 must also submit their fingerprints to the Office. Please refer to our website at www.floir.com/home/company-admissions/fingerprint-instructions for specific instructions on the payment for and submission of fingerprints. Information about the uses and retention of fingerprints is included in form OIR-C1-938.

In addition, pursuant to Section 119.071(5), Florida Statutes, social security numbers collected by an agency are confidential and exempt from disclosure under Section 119.07(1), Florida Statutes, and Section 24(a), Art. I of the State Constitution, and must be segregated on a separate page, which is included as part of form OIR-C1-938, which must be submitted as part of the Biographical Information Package.

APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION

CHECKLIST

Applicant Name: _____

Federal Identification Number ("FEIN"): _____

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

Phone Number: _____

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

SECTION I - APPLICATION FORM & FEES

- ☐ **1.** Application fee paid
- ☐ **2.** Rehabilitation Administration Expense fee paid
- ☐ **3.** Assessment fee paid
  - ☐ **a.** Copy of check and transmittal letter submitted
- ☐ **4.** All fingerprint fees paid electronically
  - ☐ **a.** Copies of online payment confirmation
- ☐ **5.** Application certification
  - ☐ **a.** Submitted for two officers

SECTION II - LEGAL

- ☐ **1.** Articles of Incorporation
  - ☐ **a.** Certified by Florida Secretary of State
- ☐ **2.** Bylaws
  - ☐ **a.** Certified by Secretary
- ☐ **3.** Certificate of Status from Florida
- ☐ **4.** Authorization Letter
- ☐ **5.** Fictitious Name Filing (if applicable)

CHECKLIST

Applicant Name: _____

SECTION III - FINANCIAL

- ☐ **1.** Insurance
  - **a.** Evidence of insurance or self-insurance
    - ☐ **i.** If not self-insured provide copies of the following:
      - ☐ **1.** General liability
      - ☐ **2.** Medical malpractice or general liability
  - ☐ **b.** Copy of fidelity bond
  - ☐ **c.** Description of risk plan, and copies of catastrophic or reinsurance coverage as applicable
- ☐ **2.** Financial Statements
  - ☐ **a.** Copy of most recent audited certified public accountant's report
  - ☐ **b.** Quarterly financial statements
- ☐ **3.** Plan of operations
  - ☐ **a.** All required elements
  - ☐ **b.** Small Employer Carrier's Application To Becomes A Risk Assuming Carrier Or A Reinsuring Carrier, As Required By Section 627.6699(9), Florida Statutes (Form OIR-B2-1093) if applicable
  - ☐ **c.** Medicaid information if applicable
- ☐ **4.** Marketing and growth
- ☐ **5.** Pro forma
  - ☐ **a.** Statement of Changes in Financial Position
  - ☐ **b.** Statement of Cash Flows
- ☐ **6.** Statement of initial cash
  - ☐ **a.** Audited financial statements of any guaranteeing organization
- ☐ **7.** History
- ☐ **8.** Insolvency protection
  - ☐ **a.** Deposit in accordance with Section 641.285, Florida Statutes
- ☐ **9.** Contingency plans
- ☐ **10.** Feasibility study

☐ **11.** Contracts

☐ **a.** Copy of each type of contract made or to be made between Applicant and any providers regarding the provision of health care services

☐ **b.** Copy of the form of any contract made or to be made between Applicant and various employees

☐ **12.** Grievance procedures

☐ **13.** Bankruptcy proceedings

☐ **a.** Evidence of compliance should contain:

☐ **i.** Delinquency acknowledgment

☐ **ii.** Waiver of right to file or be subject to bankruptcy proceeding

☐ **iii.** Acknowledgement regarding bankruptcy and Certificate of Authority

☐ **14.** Health care provider certificate

SECTION IV - MANAGEMENT

☐ **1.** Management Information Form (Form OIR-C1-2221)

☐ **a.** Submitted for all required entities

☐ **b.** Organizational chart showing all affiliated entities (if applicable)

☐ **2.** Biographical Information Package submitted for all required individuals

☐ **a.** All information completed (no blanks)

☐ **b.** "Yes" answers explained

☐ **c.** Signed

☐ **d.** Notarized

☐ **3.** Background investigative reports for all required individuals. The reports must be based on the Biographical Information Packages submitted to the Office with this Application.

☐ a. Proof of order and confirmation of payment submitted to the Office

☐ **4.** A Fingerprints and Social Security Number form (Form OIR-C1-938) for each required individual

☐ **a.** All information completed (no blanks)

☐ **b.** Fingerprints submitted for each individual required to file a Biographical Information Package

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 operate a health maintenance organization in Florida; 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 represents that they have the authority to bind the Applicant, and that by their signature on the instrument, the Applicant has executed the instrument.

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

By: _____

[Corporate Seal]

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) (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 _____