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 by selecting iApply – Online Company Admissions at the following link:

https://www.floir.com/iportal

Any questions concerning this application packet or iApply for Life and Health applicants may be directed to lhappcoord@floir.com. Property and Casualty applicants are directed to pcappcoord@floir.com.

APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION

Pursuant to Section 641.2015 and 641.19, Florida Statutes, in order to qualify as a Health Maintenance Organization, 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 the applicant and the Office. To schedule a conference, please email lhappcoord@floir.com or call (850) 413-2512.

INSTRUCTIONS
SECTION I - APPLICATION FEES AND FORM

Section I-1 Application Fee

The application filing fee is $1,000. [s.641.29(1),F.S.]

Secure the check to the invoice, which is included in this package, and send to:

Department of Financial Services
Revenue Processing Section
PO 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 pay a fee for the processing of the fingerprint cards required in Section IV-4. Florida residents have the option of having their fingerprints digitally scanned rather than providing paper fingerprint cards. Please see Form OIR-C1-938, Fingerprint Payment and Submission Procedure for instructions.

Section I-3 Deposits and Assessments

A. Submit a check for $10,000 made payable to "Commissioner of Insurance Regulation, State of Florida-Rehabilitation Administrative Expense Fund" to comply with Section 641.227(1), Florida Statutes. Mail the check to:

Department of Financial Services
Revenue Processing Section
PO Box 6100
Tallahassee, Florida 32314-6100

Submit a copy of the invoice and a copy of the check with your application filing.

B. Submit a check for $25,000 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-4 Application for Certificate of Authority (Official Form Attached)

An original signature by the president or chief executive officer and one other authorized officer must appear on the application form under corporate seal.

SECTION II - LEGAL

Section II-1 Articles of Incorporation

Submit Articles of Incorporation and all amendments certified by the Florida Secretary of State's office. The certification must be an original.

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

Submit an original certificate of status by the Florida Secretary of State's office demonstrating that the company is in good standing. You may contact the Florida Secretary of State's office at (850) 245-6052 for further information in obtaining this certificate.

Section II-3 Company Bylaws

Submit a copy of the company's bylaws, rules and regulations or similar form of document, if any, regulating the conduct of the affairs of the applicant. 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. The signature must be original and under the company's corporate seal.

Section II-4 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 II-5 Authorization Letter

A letter of authorization is required for anyone other than company personnel or the company sponsoring agent, designating the named individual to represent the applicant.

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 of Insurance Regulation listed on the policies for purposes of notification of any modification, cancellation or termination of the policies:

(1) General liability

(2) 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, issued by an **authorized insurance carrier** in this State 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 executed copies of the applicable policy with the Office of Insurance Regulation. 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 application page number, the application 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 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 s. 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.

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-3(a) 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-3(b) 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 three-year period (or break-even), as well.

Section III-3(c) 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, audited financial statements should be submitted for these entities.

Section III-3(d) 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-3(e) 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 with the Office of Insurance Regulation in the amount of $300,000.00.

Section III-3(f) 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-3(g) 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 CPA 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-4 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-5 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-6 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 IV - MANAGEMENT

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

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

A. List the names, addresses and official positions of each officer, director and person having direct or indirect control of the organization, including but not limited to contracted management company personnel (Management Information Form, OIR-C1-2221).

B. List the names of each stockholder owning five percent or more of voting securities of the applicant or any person having the right to acquire in excess of ten percent 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 HMO, 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 Stockholders

Provide a Biographical Affidavit (Form OIR-C1-1423) for each officer, director, 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.

The requirements 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 page 6 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 mark CONFIDENTIAL at the top and bottom of the separate page.

Section 119.071(5), Florida Statutes, gives authority for an agency to collect social security numbers if imperative for the performance of that agency's duties and responsibilities as prescribed by law. Limited collection of social security numbers is imperative for the Office of Insurance Regulation. The duties of the Office of Insurance Regulation in background investigation are extensive in order to 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-3 Background Investigative Reports

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 directly to the Office prior to or contemporaneously with the submission of the application filing. Please refer to Form OIR- C1-905 for instructions.

Section IV-4 Fingerprint Cards

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

SECTION V - FORMS AND RATES

Note: submit three (3) original copies of each referenced form and rate filing.

Section V-1 Forms

A. Submit three copies of each policy, master 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 HMO 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 comprehensive health care 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

A. 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. 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;
(3) Present an adequate description of the rating methodology, following consistent and equitable actuarial principles.

B. Furnish a statement from a qualified independent actuary that the HMO is actuarially sound.

APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION

CHECK LIST
SECTION I - APPLICATION FEES AND FORM

Company Name: _____

Item #			Completion Check List
1.		Application Fees Paid	☐
	(a)	Copy of invoice included (Official Form)	☐
	(b)	Copy of check included	☐
	(c)	Check mailed to address on Invoice	☐
2.		Fingerprint fee paid electronically	☐
	(a)	Copy of on-line payment confirmation	☐
3.		Deposits and Assessments	☐
	(a)	Copy of $10,000 check and copy of Invoice	☐
	(b)	Copy of $25,000 check and copy of cover letter	☐
4.		Application for Certificate of Authority (Official Form)	☐
	(a)	Application form completed	☐
	(b)	Sealed by corporation	☐
	(c)	Signed by President and other authorized officer (original signature)	☐
	(d)	Notarized	☐

SECTION II - LEGAL

Item #		Completion Check List
1.	Articles of Incorporation	☐
	(a) Original certification by Florida Secretary of State	☐
	(b) Articles with all amendments attached	☐
2.	Certificate of Status from Florida Secretary of State, signed by proper public official (original document)	☐
3.	Corporate bylaws, rules and regulations, and/or Constitution	☐
	(a) Signed and dated by corporate secretary	☐
	(b) Corporate seal affixed.....	☐
	(d) Board Resolution	☐
4.	Health Care Provider Certificate	☐
	Documentation of a Health Care Provider Certificate or proof of a pending application with AHCA	☐
5.	Outside Representative Authorization Letter	☐

SECTION III - FINANCIAL AND RELATED INFORMATION

Item #			Completion Check List
1.	Insurance		☐
	(a)	Copy of current general liability policy or plan for self-insurance ..... and Current medical malpractice policy or plan for self-insurance	☐ ☐
	(b)	Evidence of current fidelity bond	☐
	(c)	Reinsurance treaty	☐
2.	Financial Statements		☐
	(a)	Current audited financial statements	☐
	(b)	Quarterly financial statement	☐
3.	Plan of Operations		☐
	(Small Employer Carrier Application, if applicable)		☐
	(a)	Marketing and Growth	☐
		(1) Description of marketing methods	☐
		(2) A statement describing the applicant, facilities and personnel, etc	☐
		(3) Statement of geographic area to be served	☐

Item #			Completion Check List
	(b)	Pro Forma Statements	☐
		(1) Balance sheet	☐
		(2) Income statement	☐
		(3) Cash flow analysis	☐
		(4) Change in financial position	☐
	(c)	Statement of Initial Cash	☐
		Provisions for contingencies	☐
	(d)	History	☐
	(e)	Insolvency Protection Deposit with the Office	☐
		(1) Deposit with the Office	☐
		or	
		(2) Reinsurance Policy	☐
		or	
		(3) Guarantee Arrangement	☐
	(f)	Contingency Plans	☐
	(g)	Feasibility study	☐
4.	Contracts		☐
	(a)	Provider contract form and signature pages	☐
	(b)	Other forms of contracts	☐

Item #		Completion Check List
5.	Grievance Procedure	☐
	(a) Formal and informal steps included	☐
6.	Bankruptcy Proceedings	☐
	(a) Acknowledgement filed	☐
	(b) Waiver for bankruptcy proceeding	☐
	(c) Acknowledgement for bankruptcy proceeding	☐

SECTION IV - MANAGEMENT

Item #		Completion Check List
1.	Listing of all officers, directors, and shareholders (including entities owning 10% or more of applicant (Form OIR-C1-2221).....	☐
2.	Listing of all immediate parent(s) officers, directors and shareholders (including entities) owning 10% or more of parent company's stock (Form OIR-C1-2221).	☐
3.	Listing of all intermediary 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-C1-2221). Note, do not complete Form OIR-C1-1423 (Biographical Affidavits), or order investigative reports or fingerprint cards.....	☐
4.	Listing of all ultimate parent(s) officers, directors and shareholders (including entities) owning 10% or more of parent company's stock (Form OIR-C1-2221)	☐
5.	Organizational Chart including all entities within the ultimate parent company structure	☐
6.	Biographical Affidavits for company officers, directors and shareholders (including entities) owning 10% or more of applicant (Form OIR-C1-1423)	☐

As to each biographical:

(a)	All blanks completed	☐
(b)	"Yes" answers explained	☐
(c)	Contains original signature	☐
(d)	Notarized (original)	☐
(e)	Original of each affidavit submitted.....	☐
(f)	SSN on a separate page.....	☐

Item #		Completion 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) "Yes" answers explained	☐
	(c) Contains original signature	☐
	(d) Notarized (original)	☐
	(e) Original and one copy of each affidavit submitted	☐
	(f) 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) "Yes" answers explained	☐
	(c) Contains original signature	☐
	(d) Notarized (original)	☐
	(e) Original and one copy of each affidavit submitted	☐
	(f) 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..... ☐

12. Fingerprint cards enclosed 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 enclosed 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 enclosed for each ultimate 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) ..... ☐

SECTION V - FORMS AND RATES

Item #			Completion Check List
1.	Forms		☐
	(a)	3 copies of each form	☐
	(b)	Identified by unique form number	☐
2.	Rates		☐
	(a)	3 copies of each rate schedule and or contract placed with original application	☐
	(b)	Rates are neither inadequate, excessive, nor unfairly discriminatory	☐
	(c)	Rates are appropriate for class	☐
	(d)	Description of rating methodology	☐
	(e)	Statement from a qualified actuary that the HMO is actuarially sound	☐

APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION

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_____, that
(Entity Name)
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

RETURN THE COMPLETED CHECK LIST WITH THE APPLICATION PACKAGE.

APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION

Pursuant to Chapter 641, Part I, Florida Statutes, application is hereby submitted to form and operate a Health Maintenance Organization.

Proposed name of Health Maintenance Organization:

NAME: _____

ADDRESS: _____

CITY:_____STATE:_____ZIP CODE: _____

FEDERAL IDENTIFICATION NUMBER: _____

PHONE: _____

SOLVENCY CONTACT PERSON: _____

ATTORNEY OR PRINCIPAL FILING THIS APPLICATION:

NAME: _____

ADDRESS: _____

CITY:_____STATE:_____ZIP CODE: _____

PHONE: _____

This company, through its duly authorized officers, hereby applies for a certificate of authority authorizing and empowering it to operate as a Health Maintenance Organization in the state of Florida, under the laws thereof, and do hereby swear or affirm that all of the responses, information, exhibits, and documentary evidence submitted in support of this application are true and correct.

APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION

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 acquire a Florida insurer, either directly, indirectly, or via merger; 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 _____ (type of authority; e.g., officer, trustee, attorney in fact) for _____ (company name).

_____
(Signature of the Notary)

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

Personally Known _____ OR Produced Identification_____

Type of Identification Produced_____

My Commission Expires: _____

OIR-C1-942
REV 5/22
69O-191.027

APPLICATION FOR CERTIFICATE OF AUTHORITY
HEALTH MAINTENANCE ORGANIZATION

INVOICE

NAME OF HEALTH MAINTENANCE ORGANIZATION: _____

_____

FEIN#: _____

ADDRESS: _____

CITY, STATE & ZIP CODE: _____

PHONE NUMBER: _____

ADDRESS (IF DIFFERENT FROM ARRANGEMENT ADDRESS)

_____

(CITY) _____ (STATE) _____ (ZIP CODE)

In reference to the submission of the above-referenced insurer's application to do business in Florida, it is necessary for this form to be returned with proper payment.

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.

For Accounting Use Only

B/T	TY/CL	F/T	AMOUNT
C	12/47	F	$1,000

OIR-C1-942
REV 5/22
69O-191.027