



**APPLICATION FOR CERTIFICATE OF AUTHORITY  
PREPAID LIMITED HEALTH SERVICE 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.flor.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.flor.com/iportal>

Any questions concerning this application packet or iApply for Life and Health applicants may be directed to [lhappcoord@flor.com](mailto:lhappcoord@flor.com). Property and Casualty applicants are directed to [pcappcoord@flor.com](mailto:pcappcoord@flor.com).

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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-5. Please see Form OIR-C1-938, Fingerprint Payment and Submission Procedure, for instructions.

**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.

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**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.

**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.

**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.

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**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.

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**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.

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**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.

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**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. Provide the listing using Management Information Form, OIR-C1-2221.

**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 Affidavits**

Provide a National Association of Insurance Commissioners ("NAIC") Biographical Affidavit (NAIC Form 11) (Form OIR-C1-1423) for each individual listed in Section IV-1. Please note that if an individual has a Biographical Affidavit with an associated background report on file with the Office, and the Biographical Affidavit was signed and notarized within 2 years of the date of the Application being filed, a Biographical Affidavit and associated background report need not be submitted for that individual.

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

Each Biographical Affidavit must be signed and notarized.

The affiant's social security number must be submitted to the Office. Section 119.071(5), Florida Statutes, gives authority for an agency to collect social security numbers if imperative for the performance of that agency's duties and responsibilities as prescribed by law. Limited collection of social security numbers is imperative for the Office to insure that the owners, management, officers, and directors of any entity regulated by the Office are competent and trustworthy, possess financial standing and business experience, and have not been found guilty of, or not pleaded guilty or nolo contendere to, any felony or crime punishable by imprisonment of one year.

However, pursuant to Section 119.071(5), Florida Statutes, social security numbers collected by an agency are confidential and exempt from Section 119.07(1), Florida Statutes, and Section 24(a), Art. I of the State Constitution and must be segregated on a separate page. Therefore, please include the affiant's name and social security number on the separate page marked CONFIDENTIAL and provided in this packet and attach that page to the NAIC Biographical Affidavit (NAIC Form 11) that is also included in this packet.

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**Section IV-4 Background Investigative Report**

A Background Investigative Report must be provided for each person for whom a Biographical Affidavit is required, as described above. Background reports must be submitted by an approved background investigation vendor directly to the Office. Attach proof of payment confirming that all background reports have been ordered when submitting the application. Please refer to Form OIR-C1-905, Instructions for Furnishing Background Investigative Reports, included in this packet.

The NAIC approved background investigation vendor list can be found at:

[https://www.naic.org/documents/industry\\_ucaa\\_third\\_party.pdf](https://www.naic.org/documents/industry_ucaa_third_party.pdf)

**Section IV-5 Fingerprint Cards**

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

**Section IV-6** A statement generally describing the applicant, its facilities and personnel, and the limited health service to be offered.

**Section IV-7** A description of the subscriber complaint procedures to be established and maintained as required under Section 636.038, Florida Statutes.



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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.

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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"/>

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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"/>
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"/>
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) Board Resolution .....	<input type="checkbox"/>

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**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"/>

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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"/>

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**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"/>

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**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"/>

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SECTION IV - MANAGEMENT

Company Name: \_\_\_\_\_

Item #	Completion Check List
1. Alphabetical listing of officers, directors, trustees, etc (OIR-C1-2221) ...	<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 (Form OIR-C1-1423).....	<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"/>



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

Item #	Completion Check List
4. Investigative Background Report for each individual listed in Section IV-3 (Form OIR-C1-905) .....	<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"/>
(d) Proof of payment.....	<input type="checkbox"/>
5. Fingerprint cards enclosed for each person listed Section IV-3.....	<input type="checkbox"/>
(a) Contains original signature.....	<input type="checkbox"/>
(d) All blanks filled in.....	<input type="checkbox"/>

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**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"/>

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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  
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**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.

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- (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.

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**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: \_\_\_\_\_

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

<b>Lines of Business</b>	<b>Code Numbers</b>
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

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INVOICE  
REQUEST FOR PAYMENT OF APPLICATION  
FEES

NAME OF PREPAID LIMITED HEALTH SERVICE 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 the check and invoice only to the Florida Department of Financial Services, Bureau of Financial Services, Post Office Box 6100, Tallahassee, Florida 32314-6100.
2. Include a copy of the check and a copy of the invoice with the completed application package that is submitted to the Office of Insurance Regulation, Company Admissions, 200 East Gaines Street, Larson Building, Tallahassee, Florida 32399-0332.

For Accounting Use Only

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<u>BIT</u>	<u>TY/CL</u>	<u>F/T</u>	<u>AMOUNT</u>
C	10/36	L	\$500.00