Health Maintenance Organization

Application for

Certificate of Authority

Name of Insurer: NAIC Code: -- \_\_\_\_\_\_\_\_

 Group Code

FEIN: Phone: Fax:

Statutory Home Office Address:

Mailing Address (if different):

Physical location address (if different):

Is this application for the limited purpose of offering a Medicare Advantage Plan and/or a Prescription Drug Plan (Part D) in Maine under a contract with CMS? [ ]  Yes OR [ ]  No

TYPE OF OWNERSHIP (Legal Entity)

[ ]  Individual [ ]  Corporation [ ]  Profit [ ]  Cooperative

[ ]  Partnership [ ]  Association  [ ]  Non-Profit [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TO THE INSURANCE SUPERINTENDENT OF THE STATE OF MAINE:

We hereby apply for a Certificate of Authority to be licensed as a Health Maintenance Organization in the State of Maine in compliance with Title 24-A, MRSA, Chapter 56.

By signing this application, the President, Secretary, Treasurer or Attorney-in-Fact herein represents that the Company has fully complied with the provisions of its charter and by-laws, that the application contains all requirements of Maine laws and rules, and that it is true, accurate, and complete to the best of my knowledge and belief.

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| (Corporate Seal) |  Signature Printed name Title Date |