ADMITTANCE QUESTIONNAIRE FOR CERTIFICATE OF AUTHORITY OF MANAGED CARE ORGANIZATION

The following data is being submitted to the Delaware Department of Insurance:

1. Company Name: _____

   Home Office: _____

   _____

   Contact Person: _____

   Email / Telephone: _____

   Counsel: _____

   Email / Telephone: _____

2. Proposed location of principal place of business within the State:

   _____

   Address at which all books, accounts and documents relating to business in this State will be kept:

   _____

   If applicant is a foreign proprietorship, partnership, or corporation, address of principal place of business:

   _____

3. Applicant is:
   - (☐) Individual Proprietor
   - (☐) Partnership
   - (☐) Corporation
   - (☐) Other (Specify) _____

4. If applicant is a corporation (Attach Certificate of Incorporation)

   (a) State of Incorporation: _____

   (b) Date of Incorporation: _____

   (c) If a foreign corporation, name and address of Agent for Service of Process in Delaware:

   _____

Form H-2
Last updated 06/2020

5. If applicant has engaged previously in the same or a similar business; provide details, including name(s), address(es), and date(s) first commenced:

_____

_____

_____

_____

_____

6. State whether applicant is, directly or indirectly, under common ownership, control, or management or is otherwise affiliated or associated with any insurer, or any person, firm or corporation having to excising control of an insurer.

(☐) Yes, supply complete details (☐) No

7. If applicant is a partnership:

(a) State whether general partnership or limited partnership:

_____

(b) Give names and addresses of all partners specifically identifying limited partner, if any:

_____

_____

_____

_____

8. If applicant is a corporation, trust, other entity, other than a partnership, of which ownership is manifested by shares, identify each type of shares and state:

(a) Number of shares authorized: _____

(b) Number of shares outstanding: _____

(c) Par Value: _____

(d) Give name, residence address, title and number and percent of shares directly or beneficially owned by every officer(s) and director(s) and every person, firm or corporation owning or controlling 10% or more of the shares of each type:

Name	Residence Address	Title	Number of Shares (%)

9. Attach current, certified financial statement, which is as of the following date:

_____

10. If applicant, or subsidiary, affiliated, or associated health maintenance organization, has more than one place of business, give the name and address of each:

_____

_____

_____

_____

_____

_____

11. If the appropriate is “yes” to any of the following questions concerning the applicant, manager, any officer, director, owner or beneficial owner of 10% or more of the shares, complete details must be given, including name, address, disposition of charges, etc.

    Have any of the above:

    (a) Applied previously in this State for a license to engage in the business of a managed care organization? (☐) Yes (☐) No

    (b) Received a rejection, revocation or suspension of license under laws of this State governing a managed care organization? (☐) Yes (☐) No

    (c) Received a rejection, revocation, suspension under a managed care organization law or regulation, or similar law or regulation in any other State? (☐) Yes (☐) No

    (d) Received a revocation or suspension of any licensee, been convicted or entered a plea of guilty or nolo contendere, which is respect to any law or regulation relating to the business of insurance? (☐) Yes (☐) No

    (e) Been arrested, indicted, convicted, entered a plea of guilty or nolo contendere with respect to a State or Federal offense in this or any other State? (☐) Yes (☐) No

    (f) Been placed in voluntary or involuntary, bankruptcy, receivership, trusteeship, or conservatorship? (☐) Yes (☐) No

    (g) Do any of the above now hold a license to engage in the business of managed care organization, or a similar or related business in any State, District or Territory of the United States? (☐) Yes (☐) No

AFFIDAVIT

County _____

State _____

I, _____, the undersigned being the _____
(Title, if a corporation)

of the _____ swear, (or affirm), that to the
(Name of Managed Care Organization)

best of my knowledge and belief, the statements contained in this application, including the accompanying statements (if any), are true and complete.

By: _____

Title: _____

Subscribed and sworn to before me this _____ day of _____, 20___.

_____
(Notary Public)

Form H-2
Last updated 6/2020