



**STATE OF MAINE
Bureau of Insurance**

34 State House Station
Augusta, ME 04333-0034

**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.

Signature

Printed name

Title

Date

(Corporate Seal)