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

(Corporate Seal)

_____
Date