Department of Consumer & Business Services
Division of Financial Regulation
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350 Winter St. NE, Salem, Oregon
Phone: 503-947-7982, Fax: 503-947-7862
E-mail: Orinsreg.ins@oregon.gov
dfr.oregon.gov

Discount Medical Plan Organization Application

You must submit the following with your application for it to be complete:

1. Federal identification number or IRS taxpayer identification number: ______________
2. Name of applicant: ______________
3. Assumed business name (if applicable): ______________
4. Other identities (if applicable): ______________
5. Street address: ______________
   City: ______________ State: ______________ ZIP: ______________
6. Mailing address: ______________
   City: ______________ State: ______________ ZIP: ______________
   Phone: - - Fax: - - E-mail: ______________
7. Principal business address: ______________
   City: ______________ State: ______________ ZIP: ______________
   Phone: - - Fax: - - E-mail: ______________
8. Organization Web site address: ______________
9. Toll-free number for member assistance: ______________
10. Contact person for application: ______________
    Phone: - - Fax: - - E-mail: ______________
11. Domicile: ______________ Established date: ______________
12. The name of and contact information for a person that the applicant has designated to provide information to consumers or answer consumer questions.
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13. Registered office and agent for legal services in Oregon:
    a. ______________
       (Name of registered agent at registered office)
       ____
       (Address of registered office, including street, number, city, state, and ZIP)
    or
    b. Executed power of attorney appointing the director as the agent for all legal services. Complete form 440-4779.

Discount medical plan organizations must comply with ORS 742.420 through 742.440.

14. Provide a list of individual provider or providers included in the provider network that provide services in this state and a list of the medical and ancillary services the applicant offers or intends to offer to plan members as part of a discount medical plan. Alternatively, confirm this information is on the Web site address provided in item 8 above.

15. A list of the people that the applicant has authorized or intends to authorize to market a discount medical plan in this state under a name that is different from the applicant's name.

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16. a. The name, trade name, service mark, or other means by which a consumer can identify the discount medical plan the applicant offers or intends to offer, and

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b. Any different name, trade name, service mark, or other means the applicant uses to identify the same discount medical plan to people other than consumers.

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17. NAIC biographical affidavit for each principal officer, member of the board of directors, partner (owning 10 percent or more), and each principal owner (defined as owning or having the right to acquire 10 percent or more of the applicant's voting securities).

18. A list of all states and provinces of Canada in which the applicant currently holds a license, registration, or certificate of authority to transact business as a discount medical plan organization, or has held such a license or certificate within 10 years prior to the date of the application.

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19. Attach copies of the applicant's audited financial statements or unaudited financial statements and signed federal tax return for the most recent year. If the applicant has been in business less than three years, provide the applicant's business plan, including a three-year pro forma.

20. Describe the applicant's experience and expertise to operate a discount medical plan organization.

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21. CHARACTER STATEMENT

a. Has the applicant ever been denied a license or other authority in another jurisdiction to operate as a discount medical plan organization?
☐ Yes ☐ No

b. Has the applicant's license or other authority to operate as a discount medical plan organization in another jurisdiction ever been suspended or revoked?
☐ Yes ☐ No

c. Has any license or registration of the applicant to act in any occupational or professional capacity ever been refused, revoked, or suspended in this or any other state?
☐ Yes ☐ No

d. Has the applicant ever filed for bankruptcy or been adjudged a bankrupt?
☐ Yes ☐ No

If the answer to any of the above questions is yes in any respect, please provide the name and address of the licensing or registration agency, the date of the complaint or the action taken against the license or registration, a description of the nature of the complaint or the reason for the action taken against the license or registration, and, with regard to a complaint, a description of the licensing or registering agency's disposition of the complaint.

Please also provide reasons why the existence of any of these circumstances should not be used by the director as evidence that the applicant is not of "good character" and form the basis for a denial of a license.

We, ___________________________________ , president, and ___________________________ secretary, certify that we are officers of the organization named in the foregoing application, that we know the contents thereof, and each of the statements and answers made is true and complete to the best of our knowledge and belief. Further, the organization submits to the jurisdiction of any court of competent jurisdiction in Oregon for the adjudication of any issues arising out of its discount medical plans, agrees to comply with all requirements necessary to give such court jurisdiction, and will abide by the final decision of such court or any appellate court in the event of an appeal.

______________________ Date

____ President

____ Secretary