The State of New Hampshire
Insurance Department
21 South Fruit Street, Suite 14
Concord, NH 03301

Discount Medical Plan Organization Application
Registration Due June 1st every year

☐ Initial Application, $300 ☐ Renewal Application, $150
Make Check payable to, "Treasurer, State of New Hampshire"

Section 1 – Applicant Information

Discount Medical Plan Organization Name: ________________________________

Business Address (Physical Location): ____________________________________

City: _____________________ State: ____ Zip: ___________

Business Mailing Address: ____

City: _____________________ State: ____ Zip: ___________

FEIN Number: ___________________________

Toll Free Member Assistance Phone: ______________________

Business Website: _____________________________________

Location of Organization's Books and Records for NH Business:

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City: _____________________ State: ____ Zip: ___________

Type of Organization: ☐ Corporation ☐ LLC ☐ LLP ☐ Partnership

☐ Sole Proprietorship ☐ Other (attach documents)

Date Organization was Incorporated or Formed: ________________

State Organization was Incorporated of Formed: ________________

Application approval should be sent to (include name and address):

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Please identify all Names, Trade Names, Service Marks, or other means by which a consumer can identify the Discount Medical Plan the Applicant offers or intends to offer. (Applicant may attach a separate sheet of paper in necessary):

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Please identify any D/B/A's that the Applicant will be operating as:

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Section 2 – Applicant Primary Contact Information

Officer, Owner, Partner, Director, or Board Member

First Name: _____________________ Middle Initial: __

Last Name: _____________________ Suffix: ____ SSN: ______________________

Title: _______________________ Business Phone Number: ___________________

Business Email: __________________________

Mailing Address: ____

City: _____________________ State: ____ Zip: ___________

Section 3 – Contact Information for Agent for Service of Process

First Name: _____________________ Middle Initial: __

Last Name: _____________________ Suffix: ____ SSN/FEIN: __________________

Title: _______________________ Business Phone Number: ___________________

Business Email: __________________________

Mailing Address: ____

City: _____________________ State: ____ Zip: ___________

Section 4 – Compliance Contact

First Name: ____________________ Middle Initial: __

Last Name: ____________________ Suffix: ____

Title: ______________________ Business Phone Number: __________________

Business Email: _________________________

Mailing Address: ____

City: ____________________ State: ____ Zip: ___________

Section 5 – Applicant Background Information

The applicant must attach a full explanation for any questions answered "yes" as an attachment to this application. All written statements submitted by the application must include an original signature and reference the applicant's name and identifying SSN or FEIN number.

Question	Yes	No
Has the Applicant, or any Owner, Partner, Officer, Board Member, Director, or Authorized Producer of the business entity been refused a license to act as a licensed insurance producer, or has any license to act as such, ever been denied, suspended, non-renewed, revoked, cancelled, or surrendered for any disciplinary reason in any state?	☐ Yes	☐ No
Has the Applicant, or any Owner, Partner, Officer, Board Member, Director, or Authorized Producer of the business entity under investigation by any regulatory authority or subject to any regulatory action including cease and desist orders or similar actions?	☐ Yes	☐ No
Has the Applicant, or any Owner, Partner, Officer, Board Member, Director, or Authorized Producer ever been charged or convicted with committing a crime? "Crime" includes misdemeanor, felony, or a military offense. You may exclude misdemeanor traffic citations and juvenile offenses.	☐ Yes	☐ No
Has the Applicant, or any Owner, Partner, Officer, Board Member, Director, or Authorized Producer of the business entity a defendant in any lawsuit?	☐ Yes	☐ No
Has the Applicant, or any Owner, Partner, Officer, Board Member, Director, or Authorized Producer of the business entity a been convicted of a felony?	☐ Yes	☐ No
Has any demand been made, or judgement rendered against the Applicant, or any Owner, Partner, Officer, Board Member, Director, or Authorized Producer of the business entity for overdue monies by a provider of health care services, health care	☐ Yes	☐ No

provider network, pharmacy or pharmaceutical network, supplier of health care equipment, insurer, or authorized producer?		
Has the Applicant, or any Owner, Partner, Officer, Board Member, Director, or Authorized Producer of the business entity had an insurance agency contract or any other business relationship with an insurance company terminated for alleged misconduct?	☐ Yes	☐ No
Has the Applicant's license, certificate of registration, or other form of authority to operate a Discount Medical Plan Organization in another jurisdiction ever been denied, suspended, non-renewed, revoked, cancelled, surrendered, or subjected to any judicial, administrative, regulatory, or disciplinary action including but not limited to rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, or supervision in any state?	☐ Yes	☐ No
Has the Applicant changed its name or ever merged and/or consolidated with any other entity?	☐ Yes	☐ No
Has the Applicant ever declared bankruptcy? Is the Applicant currently in rehabilitation, receivership, or liquidation?	☐ Yes	☐ No

Section 6 – List all Marketers authorized by Applicant to sell, market, promote, distribute, or solicit a Discount Medical Plan established by the Applicant

Applicant may attach a separate sheet of paper if necessary – please reference "Section Number 6 continued"

Marketer Name: ____

Address: ____

City: ____________________ State: _____ Zip: ____________ Phone: _____________

Website: _________________________ Email: __________________________________

Marketer Name: ____

Address: ____

City: ____________________ State: _____ Zip: ____________ Phone: _____________

Website: _________________________ Email: __________________________________

Marketer Name: ____

Address: ____

City: ____________________ State: _____ Zip: ____________ Phone: _____________

Website: ________________________ Email: __________________________________

Marketer Name: ____

Address: ____

City: ____________________ State: _____ Zip: ____________ Phone: _____________

Website: ________________________ Email: __________________________________

Section 7 – Product Information and Miscellaneous Information

Applicant may attach a separate sheet of paper, if necessary – please refer to section number

Please describe the fees, dues, charges, periodic charges, processing fees, or other consideration that members are to be charged in exchange for access to this discount plan.

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Please provide a complete description of each distinct discount service being offered under the Discount Medical Plan.

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Please list below the participating provider or participating providers included in the provider network that provides medical services in this state and a list of the

services the participating provider and/or participating provider and/or participating provider network offers. Alternatively, confirm this information is on the website address listed on the first page of this application.

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Please list below the participating provider or participating providers included in the provider network that provides ancillary services in this state and a list of the services the participating provider and/or participating provider network offers. Alternatively, confirm this information is on the website address listed on the first page of this application.

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Please provide the current number of discount medical plan members in the State of New Hampshire

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Please provide a description of the member complaint procedures established by the Discount Medical Plan

Please list below all states in which the applicant currently holds a license, registration, or certificate of authority to transact business as a Discount Medical Plan Organization.

Describe the Applicant's experience and expertise to operate a Discount Medical Plan Organization.

Section 7 – Applicant Certification

As the applicant or as the authorized representative of the Discount Medical Plan Organization, I herby certify under penalty of perjury, that:

a) All of the information submitted in this application and attachments is true and complete. I am aware that submitting false information or omitting pertinent or material information in connection with this application is grounds for revocation or denial or registration and may subject me to administrative or criminal penalties
b) Permission is granted to the State of New Hampshire Insurance Commissioner or his designated representative to verify information with any federal, state, or local government agency, current or former employer, or insurance company.
c) All Discount Medical Plan disclosures, forms, membership cards, brochures, advertising, and contractors used will comply with insurance laws and regulations of the State of New Hampshire and Contain required information.
d) Applicant understands and will comply with the insurance laws and rules of the State of New Hampshire to which application for registration is hereby made:

Signature: ____ Date: _______________

Printed Name: _____________________________________

Notary Information

State of: _________________________

County of: ________________________

The foregoing instrument was acknowledged before me this __________ day of

_________________, 20_____, by _____________________________________, and

☐ who is personally known to me, or

☐ who produced the following identification: _________________________________

Notary Public Signature: ______________________

Printed Notary Name: ________________________

My Commissioner Expires: ____________________

Section 8 – Attachments

Applicant must submit the following with the application for it to be complete

☐ Certificate of incorporation or formation

☐ Current certificate of registration as a foreign entity issued by the Secretary of State of New Hampshire

☐ Certified copy of Charter and Bylaws

☐ Certified copy of Operating/Partnership Agreement

☐ Other organization formation documents not listed above:

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☐ Copy of Errors & Omissions Insurance (Binder pages to include carrier, limits, policy period)

☐ Copy of Directors & Officers Insurance (Bider page to include carrier, limits, policy period)

☐ Copy of the Applicant's audited financial statements or unaudited financial statements with signed federal tax return for the most recent year

☐ Provide a list of all Officers, Directors, and Board Members of the Discount Medical Plan Organization with their address and phone number

☐ Provide a list of all contractual arrangements or other arrangements with other Discount Medical Plan Organizations by providing name, address, phone number, and describe arrangement