Commonwealth of Kentucky
Department of Insurance

Insurance Purchasing Outlet Application for Registration Face Sheet

Company Name	Phone No. (800# if available)	
DBA Name	Primary Contact Person	Fed. Tax ID. No.
Business Address	Business Address	TPA License Renewal Date
Fax Number	E-Mail Address	TPA License Number

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Check Appropriate Box and **Make Check Payable to Kentucky State Treasurer**

☐ Application for Registration of a Insurance Purchasing Outlet - Fee of $250.00

☐ Application for Renewal of Registration of a Insurance Purchasing Outlet - Fee of $50.00

☐ Update of Application Information – Fee of $25.00

A FILING CANNOT BE ACCEPTED UNLESS ACCOMPANIED BY THE APPROPRIATE FEE

Certification by Person Responsible for Application

I certify that I have been authorized to submit this application by the board of directors or management committee of the company or organization listed above to make this filing.

Name (Manual Signature Required)	Position	Date

Name (Print or type)

For Department of Insurance Administrative Services Staff Only

Date: _____ Amount: _____ Check No.: _____ Initials: _____

REGISTRATION or RENEWAL OF REGISTRATION

Indicate not applicable (N/A) where appropriate

Primary Contact Person for this Application

Title: _____

Mailing Address: _____
Street

_____
City/State/Zip Code

Telephone Number: _____

Fax Number: _____

E-Mail Address: _____

SECTION A: CORPORATE PROFILE

Indicate not applicable (N/A), where appropriate

1. Please list name, title, telephone number, and e-mail address for the following positions:

Chief Executive Officer _____
Name

_____
Title

_____
Telephone

_____
Electronic Mail Address

_____
Address

Chief Financial Officer _____
Name

_____
Telephone

_____
Electronic Mail Address

_____
Address

SECTION A: CORPORATE PROFILE (continued)

Please complete or respond as follows (additional pages may be added for responses).

1. Type of Business Entity (check all that apply)

   ☐ Corporation ☐ Partnership
   ☐ Association ☐ Limited Liability Co.

   ☐ For-profit ☐ Not-for-Profit
   ☐ Public ☐ Private

   ☐ Mutual ☐ Stock
   ☐ Other (Please specify) _____

2. Date of Incorporation or formation as business entity _____

3. State of Incorporation _____

4. Attach a copy of the Applicant's Articles of Incorporation or documentation of organization as a business entity. For parts of the business that were purchased after formation of the founding organization, please describe the type of business relationship that exists between the corporate and the added business entity (e.g., amended articles of incorporation, signed meeting minutes describing relationship with new entity, letter signed by both entities stating relationship).

5. Attach a copy of the Third Party Administrators License.

6. Describe the Applicant's governing structure, including Board of Directors and standing committees, and the administration and operation of its organization. Indicate the location of the corporate or top-level organization chart in the application.

7. a. Provide the name of any holder of bonds or notes of the Applicant in an amount not less than 10% of projected annual premiums collected.

   b. Provide a certificate of an insurer authorized to write legal liability insurance in Kentucky certifying that the insurer has and will keep in effect on behalf of the insurance purchasing outlet as a result of erroneous acts or failure to act in its capacity as an insurance purchasing outlet. The policy shall provide indemnification for the benefit of any aggrieved party as a result of each single occurrence in the sum of not less than ten thousand dollars ($10,000). The policy shall not be terminated unless at least thirty (30) days prior written notice will have been given to the Commissioner and to the insurance purchasing outlet.

8. Provide a business plan, including plan of operations, marketing plan, and financial projections of no less than 3 years.

SECTION A: CORPORATE PROFILE (continued)

9. Provide the name and type of business of each corporation or other organization that the Applicant controls or with which it is affiliated and the nature and extent of the affiliation or control.

10. a. Provide the name and a biographical affidavit of each owner, partner, director, officer, and executive of the Applicant; and
    b. Provide a description of any relationship to a named individual or the Applicant has with a trade or professional association of providers, trade or association of payers, insurer as defined in KRS 304.17A-005(23), or a provider of health care services in the state of Kentucky.

11. Indicate a percentage of the Applicant's revenues that are anticipated to be derived from Insurance Purchasing Outlet business. _____.

12. If the Applicant has delegated certain functions, list the contracted individuals or companies; indicate which services they perform; and provide the information requested below. If no functions have been delegated, check "not applicable" as follows.

    ☐ Not applicable

For each individual or company, identify the following information:

- Name and title of contact person for the delegated entity
- Delegated individual or company street address
- Telephone and fax numbers of contact person
- List of services provided

13. Please enclose the following financial statements:

- Balance Sheet including Assets, Liabilities and Net Worth (Quarterly and Annual)
- Income Statement including Revenues, Expenses and Net Income (Quarterly and Annual)
- Statement of Changes in Net Worth (Quarterly and Annual)
- Statement of Cash Flow (Quarterly and Annual)
- Membership Enrollment by Month, by Quarter and Year-to-date (Quarterly and Annual)
- Notes to the Financial Statements (Quarterly and Annual)
- Management Discussion and Analysis of any significant changes or financial results (Annual Only)

14. Is the Applicant registered to perform Insurance Purchasing Outlet business in other states?

    a. ☐ YES ☐ NO

SECTION A: CORPORATE PROFILE (continued)

b. If yes, list the states. _____
_____

c. Identify any sanctions imposed or revocations of registration to perform Purchasing Outlet business and explain. _____
_____
_____

15. Indicate the hours of operation and time zone in which the Applicant is located.
_____

SECTION B. ADMINISTRATION AND OPERATION

Indicate not applicable (N/A), where appropriate

1. Provide a chart of the Applicant's organization which shows the lines of authority and, for key project staff members, their position and level of responsibility within the organization.

2. a. Provide an estimate of the number, types and functions of the personnel considered necessary to the administration and operation of the organization on a statewide basis with a separate job description detailing the roles of key persons.
   b. Include an explanation of the contractual and financial relationships between the Applicant and the insurer and/or third party administrators who will actually be responsible for processing claims or providing coverage.

3. Provide geographic area to be serviced.

4. Provide name and address of each participating insurer, if known.

5. Provide name and description of proposed health benefit plans to be offered, if known.

6. If function of the Insurance Purchasing Outlet or any portion thereof is delegated or subcontracted to another person or organization, provide a description of the oversight activities and how frequently the activities are monitored both on- and off-site (attach a copy of subcontract agreement).

7. Provide a copy of a policy and procedure relating to the written notification of the Department of Insurance of any change to this Application of Certification within thirty (30) days prior to implementation.

8. A copy of policies and procedures relating to the resolution of complaints of covered persons and providers as well as complaints that may be filed with the Kentucky Department of Insurance.

SECTION B. ADMINISTRATION AND OPERATION (continued)

9. Provide copies of policies and procedures for enrollment, including appeal procedures for denied enrollment. Please include a copy of enrollment packet and marketing materials.

10. Provide policies and procedures for accepting and redeeming vouchers. Include policy and procedures when voucher has been rejected by issuing employer.

SECTION C. CORPORATE ATTESTATION OF APPLICANT

(Must be completed by <u>all</u> Applicants)

On company letterhead, formally attest to the items listed below. The Applicant may use similar language. Have the attestation signed and dated by the appropriate officer(s) of the Applicant's organization and/or legal counsel. This Attestation should be included with the application forms. The Applicant is attesting that the following are true.

1. The information and material contained in this application is true and accurate to the best of myknowledge.

2. The documentation submitted as evidence for meeting the statutory and regulatory requirements has been reviewed by the appropriate personnel and reflects the Applicant's current structure and processes.

3. The Applicant organization, to the best of its knowledge, is in compliance with applicable state and federal laws governing confidentiality of health care information and state laws as the laws pertain to the Applicant's business.

4. The Applicant understands that the Kentucky Department of Insurance will rely on this information and material in making its decision regarding registration and that any distorted facts or misrepresentations may disqualify the Applicant from registration or result in suspension or revocation of the registration at any time.