COMMONWEALTH OF KENTUCKY
DEPARTMENT OF INSURANCE
215 WEST MAIN STREET/P.O. BOX 517
FRANKFORT, KENTUCKY 40602
502-564-6082 FAX 502-564-4604

APPLICATION FOR ORIGINAL CERTIFICATE OF AUTHORITY FOR HMO/LHSO

****Federal ID No.:_____ NAIC No.:_____ NAIC Group No.: _____**

_____,
(Name of Company)

incorporated under the laws of the State of_____ located in the City of _____, State of_____hereby makes application for a Certificate of Authority to transact in the Commonwealth of Kentucky as a:

_____ health maintenance organization or

_____ limited health service organization,

providing _____.

Describe briefly the insuring powers authorized under your charter, articles of agreement, articles of association, or other constituent document:

_____

_____

_____

The above indicated Company has caused this application to be signed by one of its proper officers at _____this _____ day of _____, _____.

Signed by: _____Title: _____
President, Vice President or Secretary