OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

1511 Pontiac Ave., Bldg. 69-1
Cranston, Rhode Island 02920
Phone: (401) 462- 9517 Fax: (401) 462-9645
www.ohic.ri.gov

Discount Medical Plan Organization
Application for Certificate of Registration
(Biennial Application)

☐ Initial Application $250.00 ☐ Renewal Application $250.00

Make check payable to: "General Treasurer, State of Rhode Island"

Section 1 – Applicant Information

1. Discount Medical Plan Organization Name			
2. Business Address (Physical Location)	3. City	4. State	5. Zip
6. Business Mailing Address (if different from above)	7. City	8. State	9. Zip
10. FEIN Number	11. Toll Free Assistance #	12. Internet Website Address	
13. Location of Organization's Books and Records for RI Business	14. City	15. State	16. Zip

17. Type of Organization ☐Corporation ☐ LLC ☐ LLP ☐ Partnership ☐Sole Proprietorship ☐ Other (attach documents)

18. Date Organization was Incorporated or Formed	19. State Organization was Incorporated or Formed

20. 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 if necessary - please reference question number)

21. Please identify any D/B/As under which the Applicant will be operating.

Section 2 – Applicant Primary Contact Information (Officer, Owner, Partner, Director or Board Member)

22. Primary Contact First Name	23. Contact MI	24. Primary Contact Last Name	25. Suffix	26. Social Security Number
27. Title	28. Business Phone Number	29. Business Email Address		
30. Mailing Address	31. City	32. State	33. Zip	

Section 3 – Contact Information for Agent for Service of Process

34. Contact First Name	35. Contact MI	36. Contact Last Name	37. Suffix	38. SSN or FEIN
39. Title	40. Business Phone Number	41. Business Email Address		
42. Mailing Address (if other than provided in Section 1)	43. City	44. State	45. Zip	

Section 4 – Applicant Background Information (The applicant must attach a full explanation for any questions answered "yes" as an attachment to this Application. Please reference question number. All written statements submitted by the application must include an original signature and reference the applicant's name and identifying SSN or FEIN number)

46. Has the Applicant, or any Owner, Partner, Officer, Board Member, Director, Affiliate or Authorized Producer of the business entity been denied a certificate of registration, license or permit to operate as a Medical Discount Plan, or has any such certificate of registration, license or permit to operate ever been suspended, non-renewed, revoked, cancelled or surrendered for any disciplinary reason in any state?	☐ Yes	☐ No
47. Has the Applicant, or any Owner, Partner, Officer, Board Member, Director, Affiliate or Authorized Producer of the business entity been under investigation by any regulatory authority or subject to any regulatory action, including cease and desist orders or similar actions within the last five years?	☐ Yes	☐ No
48. Has the Applicant, or any Owner, Partner, Officer, Board Member, Director, Affiliate or Authorized Producer ever been charged with or convicted of committing a crime? "Crime" includes a misdemeanor, felony or a military offense. You may exclude misdemeanor traffic citations and juvenile offenses.	☐ Yes	☐ No
49. Is the Applicant, or any Owner, Partner, Officer, Board Member, Director or Authorized Producer of the business entity a defendant in any lawsuit?	☐ Yes	☐ No
50. Has any demand been made or judgment rendered against the Applicant, or any Owner, Partner, Officer, Board Member, Director, Affiliate or Authorized Producer of the business entity for overdue monies by a provider of health care services, health care provider network, pharmacy or pharmaceutical network, supplier of health care equipment, insurer or authorized producer?	☐ Yes	☐ No
51. Has the Applicant, or any Owner, Partner, Officer, Board Member, Director, Affiliate or Authorized Producer of the business entity had an insurance agency contract or any other business relationship with an insurance company terminated for any alleged misconduct?	☐ Yes	☐ No
52. Has the Applicant's or any Affiliate'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 action including but not limited to rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency or supervision in any state?	☐ Yes	☐ No
53. Has the Applicant changed its name or ever merged and/or consolidated with any other entity?	☐ Yes	☐ No
54. Has the Applicant ever declared bankruptcy? Is the Applicant currently in rehabilitation, receivership or liquidation?	☐ Yes	☐ No

Section 5 – 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 5 continued)

55. Marketer Name			
56. Mailing Address	57. City	58. State	59. Zip
60. Marketer Phone Number	61. Marketer Business Website	62. Marketer Email	
63. Marketer Name			
64. Mailing Address	65. City	66. State	67. Zip
68. Marketer Phone Number	69. Marketer Business Website	70. Marketer Email	
71. Marketer Name			
72. Mailing Address	73. City	74. State	75. Zip
76. Marketer Phone Number	77. Marketer Business Website	78. Marketer Email	
79. Marketer Name			
80. Mailing Address	81. City	82. State	83. Zip
84. Marketer Phone Number	85. Marketer Business Website	86. Marketer Email	

Section 6 – Product Information and Miscellaneous Information (Applicant may attach a separate sheet of paper if necessary – please reference question number)
87. 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.
88. Please provide a complete description of each distinct discount service being offered under the Discount Medical Plan.
89. 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 network offers. Please also confirm this information is on the website address provided in item 12 above.
90. 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. Please also confirm this information is on the website address provided in item 12 above.
91. Please provide the current number of discount medical plan members in the State of Rhode Island.
92. Please provide a description of the member complaint procedures established by the Discount Medical Plan.
93. Please list below all states in which the Applicant or an Affiliate holds or has applied for a license, registration, or certificate of authority to transact business as a Discount Medical Plan Organization. Please provide the license or certification number.
94. Please describe the Applicant's experience and expertise to operate a Discount Medical Plan.

Section 7 – Applicant Verification

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 of registration and may subject me to administrative or criminal penalties.

b. Permission is granted to the Rhode Island Health Insurance Commissioner or designated representative to verify information with any federal, state or local government agency, current or former employer, provider or insurance company.

c. All Discount Medical Plan disclosures, forms, membership cards, brochures, advertising and contracts used will comply with laws and regulations of the State of Rhode Island and contain the required information.

d. The Rhode Island Health Insurance Commissioner is authorized to give any information concerning the Applicant, as permitted by law, to any federal, state or municipal agency, or any other organization and the Applicant hereby releases the State of Rhode Island, the Rhode Island Health Insurance Commissioner and any person acting on their behalf from any and all liability of whatever nature by reason of furnishing such information.

e. Applicant shall maintain in force a surety bond or deposit with the Commissioner in accordance with the requirements of R.I. Gen. Laws § 27-74-6.

f. Applicant understands and will comply with the Discount Medical Plan Organization laws and rules of the State of Rhode Island 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: _____

[SEAL]

Printed Notary Name: _____

My Commission 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 RI Secretary of State
- ☐ Certified copy of Charter and Bylaws
- ☐ Certified copy of Operating/Partnership Agreement
- ☐ Other Organization formation documents not listed above:_____
- ☐ Copy of Errors & Omissions Insurance (Binder pages to include carrier, limits, policy period)
- ☐ Copy of Directors & Officers Insurance (Binder 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.
- ☐ Proof of surety bond or deposit pursuant to R.I. Gen. Laws § 27-74-6 need not be filed with this application, however, such documentation must be provided prior to approval of registration.