



OKLAHOMA INSURANCE DEPARTMENT
FINANCIAL DIVISION
3625 NW 56th ST, SUITE 100 • OKLAHOMA CITY, OKLAHOMA 73112
(405) 522-2304 • TOLL FREE (IN STATE) 1-800-522-0071 • FAX: (405) 522-4160

APPLICATION FOR DISCOUNT MEDICAL PLAN ORGANIZATION REGISTRATION

NAME OF PLAN: _____

LEGAL CORPORATE NAME: _____

FEIN: _____

PLAN'S ULTIMATE CONTROLLING PERSON:

PLAN MAILING ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____

TELEPHONE NUMBER: _____ FAX NUMBER: _____

CONTACT PERSON NAME: _____

PLAN'S PHYSICAL ADDRESS, IF DIFFERENT FROM MAILING ADDRESS:

PLAN WEB SITE ADDRESS: _____

LOCATION OF ALL PLAN WRITTEN MATERIALS, INCLUDING FINANCIAL STATEMENTS:

Application Certification

1. This discount medical plan organization, through the applicant listed below, applies for registration with the Oklahoma Insurance Department, and certifies that the contents of this application, including all attachments, are true and correct.
2. The applicant certifies that this application, and all attachments and supplements, contain no material misstatements or misrepresentations, and this application is not being submitted for any fraudulent or dishonest purpose.

3. The applicant understands that the submission of false information in this application, or the omission of material information, is grounds for registration denial or registration revocation.
4. The applicant certifies that he or she has not committed fraud or engaged in illegal or dishonest activities in connection with the administration of a health care discount program.

Signed this _____ day of _____, 20__

Signature of Applicant

Printed name of Applicant

Title of Applicant

Applicant Address

Applicant City, State, ZIP

Applicant telephone number