



OKLAHOMA INSURANCE DEPARTMENT

FINANCIAL DIVISION

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**DISCOUNT MEDICAL PLAN ORGANIZATION
 APPLICATION FOR CERTIFICATE OF REGISTRATION
 Title 36 O.S. § 1219.4 and O.A.C. 365:10-23 (1-4)**

INITIAL APPLICATION RENEWAL APPLICATION, OK REGISTRATION # _____
 NON-EXEMPT (Fee \$250) EXEMPT PURSUANT TO Title 36 O.S. § 1219.4(B)(10)(a-d) (Fee \$100)
Checks must be made payable to the OKLAHOMA INSURANCE DEPARTMENT

Discount Medical Plan Organization Legal Name			FEIN #	
Business Type <input type="checkbox"/> Corporation <input type="checkbox"/> LLC <input type="checkbox"/> LLP <input type="checkbox"/> Partnership <input type="checkbox"/> Proprietorship <input type="checkbox"/> Other (Attach Legal Documents)				
Date Organization was Incorporate or Formed			State Organization was Incorporated or Formed	
Trade Name(s), Service Marks, Doing Business As (DBA), or Other Name(s) used by the Organization (A separate sheet of paper may be used.)				
Business Address (Physical Location)		City	State	Zip
Toll Free Assistance #	Business Telephone #		Internet Website Address	
Business Mailing		City	State	Zip
Location of Organization's Books & Records for OK Business		City	State	Zip
Primary Contact Name & Title		E-mail Address		Telephone #
Primary Contact Mailing Address		City	State	Zip
Service of Process Contact Address		City	State	Zip
Telephone #	Fax #		E-mail Address	

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