STATE OF MONTANA
STATE AUDITOR
COMMISSIONER OF INSURANCE & SECURITIES
840 HELENA AVENUE
HELENA, MT 59601

APPLICATION FOR ORIGINAL CERTIFICATE OF AUTHORITY

NAME OF APPLICANT _____
(Health Maintenance Organization)

MAILING ADDRESS _____
(Street or PO Box)

_____
(City) (State) (Zip)

*Date Incorporated _____

State of Domicile _____

HEREWITH SUBMITTED ARE THE FOLLOWING DOCUMENTS:

( ) *Certified copy of Corporate Charter or Articles of Incorporation, with all amendments.
( ) *Certified copy of Bylaws, as amended.
( ) Annual Statement as of December 31 preceding (size 9" x 14") or statement of operations if a plan.
( ) Certificate of Good Standing from the Montana Secretary of State (foreign corporation).
( ) Copy of your Certificate of Authority or Good Standing from your domiciliary state (foreign HMO only).
( ) Copy of last examination report (conducted within the last 3 years).
( ) Evidence that the deposit requirement outlined in Section 33-31-216, MCA, has been met.
( ) Copy of the fidelity bond pursuant to Section 33-31-223(2), MCA.
( ) Appointment of Attorney to Accept Service of Process (Form INSURER.SP).
( ) Uniform NAIC biographical affidavit for each officer and director of the HMO.
( ) A copy of all contracts made with each provider, officer, and director pursuant to Section 33-31-201(3)(d)(iv), MCA.
( ) Description of HMO's proposed marketing plan in Montana, including:
  a) insurance products to be marketed;
  b) how and by whom insurance products will be marketed;
  c) advertising methods to be employed.
( ) Projection of anticipated Montana premium for each of the next 5 years.
( ) Description of your geographic service area in Montana, including:
  a) chart showing the number of primary and specialty care providers with locations and service areas by county;
  b) method of handling emergency care, with the location of each emergency care facility;
  c) method of handling out-of-area services.
( ) Description of how service is to be provided enrollees in Montana.
( ) A detailed financial plan that includes a projection of operating results for the greater of either three (3) years or when the HMO is projected as profitable.
( ) A statement as to the sources of working capital and any other source of funding.
( ) Description of your procedure for handling complaints.

*Not required of a plan.

( ) Description of your mechanism which allows enrollers an opportunity to participate in matters of policy and operation pursuant to Section 33-31-222(2), MCA.

( ) Summary of how administrative services will be provided, including:
   a) size and qualifications of administrative staff;
   b) projected cost of administration in relation to premium income

( ) If the management authority for a major corporate function is conducted by a person outside the organization, submit a copy of the management contract.

( ) Summary of all financial guaranties by providers, sponsors, affiliates or parent within your holding company system or any other guaranties that are intended to ensure the financial success of the HMO.

( ) Summary of benefits to be offered enrollers, including limitations, exclusions and renewability of the contract.

( ) Evidence demonstrating that if the HMO becomes insolvent:
   a) Enrollees hospitalized on the date of insolvency will be covered until discharged;
   b) enrollees will be entitled to similar alternate coverage that does not contain any medical underwriting or preexisting limitation requirements.

( ) A copy of each reinsurance contract.

1. Are you operated by an insurer or a health service corporation as a plan?
   Yes _____ No _____ If yes, the organization _____
2. Are the medical providers affiliated with the HMO salaried employees?
   Yes _____ No _____ If yes, explain on a separate attachment.
3. Does each of your insurance policies for Montana contain a description of your complaint process pursuant to Section 33-31-303(1)(a), MCA.
   Yes _____ No _____
4. Has your HMO ever been refused admission to this or any other state prior to the date of application?
   Yes _____ No _____ If yes, explain on a separate attachment.
5. Has your license or certificate of authority ever been revoked or suspended by any state?
   Yes _____ No _____ If yes, explain on a separate attachment.
6. Has your HMO been fined by any state?
   Yes _____ No _____ If yes, explain on a separate attachment.

( ) Check No. _____ in the amount of $300 application fee.

Dated _____

_____
Name and Title of Officer

_____
Signature of Officer

Application contact person and telephone number: _____

_____

(HMOAPP.2018)

State Auditor's Office **Montana Insurance Department**

APPOINTMENT OF ATTORNEY TO ACCEPT SERVICE OF PROCESS

_____ (Name of Company), appoints THE DULY ELECTED STATE AUDITOR AND COMMISSIONER OF INSURANCE OF THE STATE OF MONTANA as its attorney to receive service of legal process issued against it in the State of Montana. The Company authorizes the Commissioner, or, in the Commissioner's absence, an employee of the Commissioner, to acknowledge service of legal process on behalf of the Company in this state. The Company does consent and agree that any lawful process against it that is served upon the Commissioner as appointed attorney shall have the same legal force and validity as if served upon the Company. The Company waives all claim or right of error by reason of acknowledgement of service. This appointment is irrevocable, binds the Company and any successor in interest or to the assets or liabilities of the Company, and remains in effect as long as there is in force in the State of Montana any contract made by the Company or obligations arising from a contract. The Company is duly organized under the laws of the State of _____ and has been admitted or is applying for authority to transact insurance in the State of Montana.

IN WITNESS WHEREOF, the said Company has to these presents affixed its corporate seal and caused the same to be subscribed and attested by its President and Secretary at the City of _____, in the State of _____, on the _____ day of _____, A.D. 20____.

_____
President

_____
Secretary

_____

_____
Name and address of the person to whom Service of Process is to be forwarded.

(INSURER.SP)

BIOGRAPHICAL AFFIDAVIT

http://csimt.gov/wp-content/uploads/NAIC-Biographical-Affidavit-Form-2015.pdf

CHAPTER 31. HEALTH MAINTENANCE ORGANIZATIONS

http://leg.mt.gov/bills/mca/title_0330/chapter_0310/parts_index.html