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 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.
( ) 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(2)(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:_____

_____

BIOGRAPHICAL AFFIDAVIT

https://csimt.gov/wp-content/uploads/industry_ucaa_form11_updated.pdf

SERVICE OF PROCESS

https://csimt.gov/service-of-process