TROY DOWNING
CSI
COMMISSIONER OF SECURITIES & INSURANCE
OFFICE OF THE MONTANA STATE AUDITOR

Medical Care Discount Card
Application Procedures for Certificate of Registration

Certificate of Registration

A medical care discount card supplier may not market, promote, sell, or distribute a medical care discount card in this state unless the supplier holds a Certificate of Registration as a supplier issued by the Commissioner.

Requirements for Certificate of Registration

1. Completed application form reviewed and approved by the Commissioner. (The application form is included with this document.)
2. Meet financial responsibility requirements outlined in Section 33-38- 106, MCA.
3. Listing of authorized enrollers provided to the Commissioner.

Exceptions

A medical care discount card supplier that is a health insurance issuer authorized to do business in Montana is not required to obtain a Certificate of Registration. The exemption is not extended to medical care discount card suppliers who are affiliates of health insurers.

An administrator that is authorized to do business in this state and provides medical care discount cards only to Montana residents who are members of self-funded group health plans administered by the administrator is not required to obtain a Certificate of Registration.

Waiver

In accordance with 33-38-107, MCA, the Commissioner may waive the registration and financial responsibility requirements for certain **preferred provider organizations.** The factors taken into account in granting the waiver include but are not limited to whether the company:

1. Has contracts in place with health care providers residing in this state;
2. Has contracts in place with users and purchasers of health care services residing in this state who use the medical care discount card in conjunction with a self-funded or fully insured health plan;
3. Is primarily in the preferred provider organization business or primarily in the medical care discount card supplier business; and
4. Was in business in this state prior to October 1, 2005.

For **preferred provider organizations** acting as medical care discount card suppliers on October 1, 2005, requests for waiver were required in writing by October 1, 2005.

For **preferred provider organizations** acting as medical care discount card suppliers that commence operation after October 1, 2005, requests for waiver must be submitted at least 30 days before commencing business as a supplier.

Filing Time Frames

A person acting as a medical care discount card supplier on October 1, 2005, was required to file an application for a Certificate of Registration with the Commissioner by October 1, 2005. For suppliers commencing operation after October 1, 2005, the application for a Certificate of Registration must be submitted at least 30 days before commencing business as a supplier. The supplier may not market, promote, sell, or distribute a medical care discount card in this state until the Commissioner issues the Certificate of Registration.

Filing Fees

There is a non-refundable filing fee of $100 for the application for Certificate of Registration. Additionally, there is $100 annual filing fee (due by December 31) for the annual renewal of the Certificate of Registration.

There is a $250 non-refundable filing fee for the establishment of financial responsibility. Additionally, there is a $250 filing fee associated with the annual certification of financial responsibility.

All fees should be submitted at the time of the applicable filing.

Biographical Affidavit Forms

Required biographical affidavits should be submitted with the application for Certificate of Registration. The biographical affidavit form can be found at:

https://www.naic.org/documents/industry_ucaa_form11.pdf

Bond Form

The bond form is provided with the application for Certification of Registration.

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Application for Certificate of Registration

1. Name of applicant (card supplier): _____

2. List all names under which Medical Care Discount Cards will be marketed in Montana:
   _____
   _____
   _____

3. Owner and/or controlling entity of Medical Care Discount Card Supplier:
   _____
   _____
   _____

4. List all Officers and Directors of the Medical Care Discount Card Supplier (a completed NAIC biographical affidavit form should be provided for each Officer and each Director):
   _____
   _____
   _____
   _____
   _____

5. Manager/Point of Contact for Montana Business (please attach completed NAIC biographical affidavit):
   Name: _____
   Street Address:_____
   Mailing Address:_____
   Phone:_____
   Fax: _____
   Email: _____

6. Principal Administrative Office Address and contact information:
   Street Address:_____
   Mailing Address:_____
   Phone:_____
   Fax: _____
   Email: _____

7. Has card supplier and/or affiliate had a previous application for certificate of registration denied, revoked, suspended, or terminated for cause or is under investigation for or has been found in violation of a statute or regulation in another jurisdiction with the previous 5 years: ☐ No ☐ Yes, please explain:
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____

8. Provide a description of the supplier's expertise and/or experience in operating a medical care discount card business. Please attach supporting documentation, if applicable:

_____
_____
_____
_____
_____

9. Describe how the Medical Care Discount Card will be advertised and/or promoted. Additionally, please provide samples of the advertising and promotional materials to be used in Montana, a sample card to be issued, and a sample of the purchase agreement. Advertising/promotional materials must comply with Sections 33-38-103 and 104, MCA.

_____
_____
_____
_____
_____
_____

10. List all health care providers (please include addresses and phone numbers) currently under contract or supply evidence that you have a contract with an established provider network. Additionally, please include information describing or illustrating how users can access a listing of all providers who participate in the network and/or honor your discount. (If needed, include attachment)

_____
_____
_____
_____
_____
_____
_____

11. Provide the name and contact information for the Medical Care Discount Card Compliance Officer: _____
Street Address:_____
Mailing Address:_____
Phone:_____
Fax: _____
Email: _____

12. List all authorized enrollers for Montana. Please include current address, phone numbers, and social security numbers: (If needed, add attachment)

_____
_____
_____
_____
_____
_____
_____

13. Please attach evidence of financial responsibility. (Section 33-38-106, MCA)

Changes must be reported promptly

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STATE OF MONTANA
MEDICAL CARE DISCOUNT CARD SUPPLIER BOND

BOND No._____ **BOND AMOUNT** _____

KNOW ALL PERSONS BY THESE PRESENTS:

That we, _____, as principal, and_____, a corporation duly organized authorized and existing under the laws of the state of_____, and authorized to do business in the state of Montana, as SURETY, are held and firmly bound unto the state of Montana, in the penal sum of $50,000 lawful money of the United States for the payment of which sum, well and truly to be made, we bind ourselves, our heirs, executors, administrators, successors, and assigns, jointly and severally, firmly by these presents.

WHEREAS, the principal is subject to the provisions of the Montana Medical Care Discount Card Act and shall faithfully comply with the provisions of the Act.

NOW, THEREFORE, THE CONDITIONS OF THIS OBLIGATION ARE SUCH, that if the above bonded principal shall faithfully comply with the provisions of the Act and the orders legally made pursuant thereto, then and in that event the forgoing obligation shall be void, otherwise to remain in full force and effect.

PROVIDED, HOWEVER, AND UPON THE FOLLOWING EXPRESS CONDITIONS: That any person or the Montana Commissioner of insurance claiming against the bond for violation of the Act occurring during the time period during which this bond is in effect may maintain an action at law against the PRINCIPAL and against the SURETY. The aggregate liability of the SURETY to all persons damaged by violations of this Act may not exceed the amount of the surety bond.

PROVIDED FURTHER, that the Surety may terminate its liability hereunder as to future acts of the Principal at any time by giving twenty-one (21) days written notice of such termination to the Montana Commissioner of Insurance.

This bond is for a definite term beginning _____, and ending _____, and maybe continued by a Continuation Certificate.

SIGNED, SEALED AND DATED THIS ____DAY OF _____ 20__

_____
(Medical Care Discount Card)

By: _____
(Principal)

By: _____
(Surety)