Ohio Department of Insurance

Mike DeWine, *Governor*
Jon Husted, *Lt Governor*
Judith L. French, *Director*

Application for Health Insuring Corporation Certificate of Authority

Office of Risk Assessment, 50 W Town Street, 3rd Floor - Suite 300, Columbus OH 43215
614-644-2647 | 614-644-3256 (Fax) | insurance.ohio.gov

Date _____

To The Director of Insurance of Ohio
50 West Town Street, Suite 300
Columbus, Ohio 43215

The _____
(Company Name)

of _____ in the State of _____
(Statutory City) (State)

hereby applies for a license to transact the business as prescribed by section(s):

Check one box based on services planned

☐ 1751.01 (A)&(B) Ohio Revised Code (Basic and Supplemental Health Care Services) *Medicaid only must select this.*
☐ 1751.01 (A)&(C) Ohio Revised Code (Basic and Specialty Health Care Services)
☐ 1751.01 (A) Ohio Revised Code (Basic Health Care Services only)
☐ 1751.01 (B) Ohio Revised Code (Supplemental Health Care Services only)
☐ 1751.01 (C) Ohio Revised Code (Specialty Health Care Services only)

The corporation is formed as a:

☐ Stock corporation, as defined by 1701, Ohio Revised Code
☐ Not for profit, as defined by 1702, Ohio Revised Code
☐ Other _____

Check here if applicable:

☐ Provider sponsored organization (PSO) as defined by 1751.01 (X), Ohio Revised Code

The Employer tax I.D. number: _____

The full name in the Articles of Incorporation:

_____

Articles of Incorporation certified by Ohio Secretary of State on _____
(date)

List any D.B.A. name and provide evidence that it has been filed with the Secretary of State:

_____

The Corporation will be a ☐ Foreign ☐ Domestic Corporation. (Check One)

Indicate the Corporation's affiliated parent corporation, name and address, if any, that will provide the corporate guaranty:

_____

Provide a contact person for questions regarding this application:

Name _____

Telephone number _____

Fax number _____

Top Executive Officer: _____

Corporate Address: (must be an Ohio address if Domestic corporation)

_____

_____

_____

Mailing address if different:

_____

_____

_____

Will the Plan serve Medicare recipients? ☐ Yes ☐ No

Will the Plan serve Medicaid recipients? ☐ Yes ☐ No

List service area by County name(s):

_____

_____

_____

_____

Total counties to be served: _____

Respectfully submitted,

_____

Secretary