

DISCOUNT MEDICAL PLAN APPLICATION FOR CERTIFICATE OF REGISTRATION

Certificate of Registration Required

A discount medical plan organization may not market, promote, sell, or distribute a discount medical plan in Nebraska unless the entity holds a certificate of registration issued by the Director of Insurance.

Requirements for Certificate of Registration

1. Completed application form reviewed and approved by the Director. The application form is included with this document.
2. Truthful and accurate responses to the application form.
3. Complete submission of any documents requested by the Director in order to review the application.
4. Maintain and present an up-to-date website containing contact information for the plan.

Exceptions:

A discount medical plan organization that is a health carrier is not required to obtain a certificate of registration under section 38 of the Discount Medical Plan Organization Act, except that each of its affiliates that operates as a discount medical plan organization in this state shall obtain a certificate of registration under section 38 of this act and comply with all other provisions of the act.

A provider who provides discounts to his or her own patients without any cost or fee of any kind to the patient is not required to obtain and maintain a certificate of registration under the act as a discount medical plan organization.

Filing Time Frames:

A person acting as a discount medical plan organization on June 30, 2008 shall file an application for a certificate of registration with the Department of Insurance by June 30, 2008.

For those that will commence operation after June 30, 2008, the application for a certificate of registration must be submitted at least 90 days before commencing business. The discount medical plan organization may not market, promote, sell, or distribute a discount medical plan in Nebraska until the Director of the Nebraska Department of Insurance issues the certificate of registration.

Filing Fees:

There is a non-refundable filing fee of \$500 for the application for Certificate of Registration. Additionally, there is a \$300 annual filing fee associated with annual renewal of the Certificate of Registration.

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.

Certificate of Registration Application Form

1. Name of applicant (card supplier): _____

2. List all names under which the Discount Medical Plan will be marketed in Nebraska. Please provide the URL and/or internet web address from which the plan may be marketed. If the URL and/or internet web address changes, those changes must be provided to the Department of Insurance immediately.

3. Owner and/or controlling entity of the Discount Medical Plan. Include an address, phone number, fax number and email where the owner and/or controlling entity may be contacted:

4. List all Officers and Directors of the Discount Medical Plan and their addresses that are responsible for the conduct of the organizations' affairs, including but not limited to any contractual or other arrangements with such persons and the discount medical plan organization. (A completed NAIC biographical affidavit form should be provided for each Officer and Director):

ANY CHANGES MUST BE REPORTED PROMPTLY

5. Have any persons listed in question four been convicted of a crime, had a judgment withheld or deferred, or are currently charged with committing a crime? "Crime" includes a misdemeanor, felony or a military offense.

If you answer yes, please attach to this application:

- a.) a written statement explaining the circumstances of each incident;
- b.) a certified copy of the charging document; and
- c.) a certified copy of the official document, which demonstrates the resolution of the charges or any final judgment

6. Please list the manager/point of contact for Nebraska business (please attach completed biographical affidavit).

Name: _____
Street Address: _____
Mailing Address: _____
Phone: _____
Fax: _____
E-Mail: _____

ANY CHANGES MUST BE REPORTED PROMPTLY

7. Have any persons listed in question six been convicted of a crime, had a judgment withheld or deferred, or are currently charged with committing a crime? "Crime" includes a misdemeanor, felony or a military offense.

If you answer yes, please attach to this application:

- a.) a written statement explaining the circumstances of each incident;
- b.) a certified copy of the charging document; and
- c.) a certified copy of the official document, which demonstrates the resolution of the charges or any final judgement.

8. Principal Administrative Office Address and contact information:

Street Address: _____

Mailing Address: _____

Phone: _____

Fax: _____

E-Mail: _____

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9. Has the Discount Medical Plan Organization and/or affiliates had a previous application for certificate of registration or application for a license denied, revoked, suspended, or terminated for cause or is under investigation for or has been found in violation of any statute, regulation or has been sued by any entity in any jurisdiction within the previous five years or is the subject of any pending action? If yes, please explain in detail below and please provide what resolution, if any, was obtained:

10. Provide a description of the Discount Medical Plan Organization's expertise in operating a discount medical plan business. Please attach supporting documentation if applicable:

11. Please provide evidence of financial stability. Please attach supporting documentation:

12. Describe how the Discount Medical Plan Organization will be advertised and/or promoted. Additionally, please provide samples of the advertising and promotional materials to be used in Nebraska, a sample card and all accompanying information provided to enrollees that will be used, and a sample of the purchase agreement. Advertising material must comply with the Discount Medical Plan Organization Act.

13. 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 (a listing may be attached). 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.

14. Provide the name and contact information for the Discount Medical Plan Organization's Compliance Officer:

Name: _____
Street Address: _____
Mailing Address: _____
Phone: _____
Fax: _____
E-mail _____

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Please promptly remit the completed application and all other corresponding documentation to:

The Nebraska Department of Insurance
Attn: Life and Health Administrator
1135 M Street, Suite 300
Lincoln, NE 68508

P.O. Box 82089
Lincoln NE 68501-2089

Please contact the Department of Insurance at 402-471-2201 with any questions you may have.