NEBRASKA DEPARTMENT OF INSURANCE

APPLICATION FOR CERTIFICATE TO TRANSACT BUSINESS AS AN INDEPENDENT REVIEW ORGANIZATION

Pursuant to Neb.Rev.Stat. §44-1312

Name of Applicant: _____

Federal I.D. # _____ **Date Incorporated** _____

Principal Business Address: _____
Street Address

_____ _____ _____ _____
City State Zip Code Phone

Mailing Address: _____
Street Address

_____ _____ _____ _____
City State Zip Code Phone

Submitter's Name: _____ **Email Address:** _____

Please submit with the application, documentation that the applicant has received approval or accreditation by the a nationally recognized private accrediting entity.

Please also include a check in the amount of $100.00 in payment of the application fee.

NEBRASKA DEPARTMENT OF INSURANCE
INSURANCE LICENSING DIVISION
P.O. BOX 82089
LINCOLN, NE 68501-2089

E-mail: DOI.Licensing@Nebraska.gov
Licensing Division: (402) 471-4913
DOI Main Line: (402) 471-2201
Fax: (402) 471-6559

List below the principal officers responsible for the operations, management and control of the applicant name herein:

Officer 1

Name:	Title:
Business Address:	
Resident Address:	
Social Security Number:	

Officer 2

Name:	Title:
Business Address:	
Resident Address:	
Social Security Number:	

Officer 3

Name:	Title:
Business Address:	
Resident Address:	
Social Security Number:	

Officer 4

Name:	Title:
Business Address:	
Resident Address:	
Social Security Number:	

This application must be signed by all named principle officers listed above.

Officer 1: _____ _____
Signature Date

Officer 2: _____ _____
Signature Date

Officer 3: _____ _____
Signature Date

Officer 4: _____ _____
Signature Date

Article 13 – Health Carrier External Review Act:
http://nebraskalegislature.gov/laws/statutes.php?statute=44-1301