

## Health Maintenance Organization (HMO) Alternative Health Care Financing and Delivery System (AFDS)

### Application for Certificate of Authority

**TYPE** of Certificate of Authority Applied For:  HMO  AFDS

Name \_\_\_\_\_  
(As Appears on Articles of Incorporation)

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone No. \_\_\_\_\_

Fax No. \_\_\_\_\_

E-mail Address \_\_\_\_\_

FEIN No. \_\_\_\_\_

Type of Ownership:

- |                                      |                                      |                                     |
|--------------------------------------|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> Individual  | <input type="checkbox"/> Association | <input type="checkbox"/> For-Profit |
| <input type="checkbox"/> Partnership | <input type="checkbox"/> Cooperative | <input type="checkbox"/> Non-Profit |
| <input type="checkbox"/> Corporation | <input type="checkbox"/> Other       |                                     |

Name of Chief Executive Officer \_\_\_\_\_

Name of Medical Director \_\_\_\_\_

Name of Authorized Representative \_\_\_\_\_

*I certify that all information and statements made in this application are true, complete and current to the best of my knowledge and belief.*

Signature of Authorized Representative \_\_\_\_\_

Authorized by PA 218 of 1956, as amended. Required by MCL 500.3509 and/or MCL 500.3573.



**Michigan Department of Energy, Labor & Economic Growth**

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