

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 Insurance and Financial Services

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