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:

☐ Individual	☐ Association	☐ For-Profit
☐ Partnership	☐ Cooperative	☐ Non-Profit
☐ Corporation	☐ 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.