**STATE OF KANSAS**
**KANSAS INSURANCE DEPARTMENT**

# CONTINUING CARE PROVIDER APPLICATION FOR NEW OR RENEWAL CERTIFICATE OF REGISTRATION

**To the KANSAS COMMISSIONER OF INSURANCE, Topeka, Kansas:**

On behalf of the _____

of _____, _____, _____
(City) (State) (Zip)

a continuing care provider created under the laws of the state of _____
I hereby apply for a CERTIFICATE OF REGISTRATION pursuant to K.S.A. 40-2231 through K.S.A. 40-2238, authorizing and empowering the above named continuing care provider to operate in the State of Kansas until such certificate is suspended, revoked or terminated by the Insurance Commissioner of Kansas.

It is hereby certified the continuing care provider making this application has complied with the requirements of K.S.A. 40-2231 through K.S.A. 40-2238.

Finally, the undersigned swears under oath (s)he has executed this application dated _____ for and on behalf of _____, that (s)he is a duly appointed representative of such provider, that (s)he is authorized to execute and file this application, and that the information contained in this application is true and accurate to the best of his/her knowledge.

_____
Signature of Applicant
(Chief Executive Officer or Executive Director)

**Please note the following requirements:**

- **NEW APPLICATION** – please complete the attached Annual Disclosure Statement.
- **RENEWAL APPLICATION** – please attach a copy of your most recent Annual Disclosure Statement.
- **ALL APPLICANTS** – *please attach annual certification audit of most recent fiscal year and copies of any continuing care contract forms.*

_____New ($50 fee) _____ Renewal ($25 fee)

Administrative Office: _____
(Street Address)

_____
(City) (State) (Zip)

_____ _____ _____
(Phone) (Fax) (Email Address)

Continuing Care Facility: _____
(Street Address)

_____
(City) (State) (Zip)

_____
(Phone)

Chief Executive Officer/Executive Director: _____
(Name)

_____
(Title)

_____
(Phone Number)