

INSURANCE DEPARTMENT
STATE OF KANSAS
HEALTH MAINTENANCE ORGANIZATION
APPLICATION FOR CERTIFICATE OF AUTHORITY

_____, 20_____

COMMISSIONER OF INSURANCE, Topeka, Kansas:

On behalf of _____
(Name of Health Maintenance Organization)

_____,
(Registered Corporate Address in State of Domicile)

incorporated on _____.
(Date)

I (We) hereby apply for a CERTIFICATE OF AUTHORITY to transact business in the State of Kansas as a Health Maintenance Organization.

Very truly yours,

Corporate President Signature

Printed Name

Corporate Secretary Signature

Printed Name

Business Mailing Address
and Telephone Number

