

**APPLICATION FOR  
CERTIFICATE OF INCORPORATION  
AND CERTIFICATE OF AUTHORITY  
NONPROFIT PLANS**



State of Wisconsin  
Office of the Commissioner of Insurance  
125 South Webster Street  
P. O. Box 7873  
Madison, WI 53707-7873  
(608) 266-3585

Ref: Ch. 613, Wis. Stat.

PLEASE COMPLETE AND RETURN TO THIS OFFICE

Name of Plan			
Street Address and/or P.O. Box			
City	State	Zip + 4	Federal Employer ID #

The \_\_\_\_\_ hereby applies for a  
(Name of Plan)

license authorizing it to transact the business of insurance authorized under ch. 613, Wis. Stat. The plan operates as the following type of insurer:

- Traditional Service Insurance Corporation
- Health Maintenance Organization
- Preferred Provider Plan
- Dental Plan (open panel)
- Vision Plan (open panel)
- Limited Service Health Organization
  - Dental
  - Vision
  - Other

As a condition precedent to and as a consideration for the issuing of the license, the plan agrees not to write or permit the writing of coverage upon the health of persons within the state of Wisconsin except pursuant to ch. 613, Wis. Stat. Further, the undersigned attest that the plan has filed with the Office of the Commissioner of Insurance all of the material required prior to incorporation and licensing.

Name of Plan	
Signature of First Executive Officer	Date
Signature of Second Executive Officer	Date

**AUTHORITY OF COMMISSIONER  
TO MAKE INQUIRY**



State of Wisconsin  
Office of the Commissioner of Insurance  
125 South Webster Street  
P. O. Box 7873  
Madison, WI 53707-7873  
(608) 266-3585

Ref: s. 611.13, 613.13, and 618.11, Wis. Stat.

**INSTRUCTIONS:** Forward completed form, with required signatures, to the above address. Failure to complete this form may result in denial of application.

I hereby authorize the Commissioner to make inquiry of any person about the

\_\_\_\_\_ (Name of Applicant)

of \_\_\_\_\_, \_\_\_\_\_ (City) (State or Country)

Its manager under a management contract, its attorney in fact, its general agents, and any of the officers, directors, or shareholders of any of them designated by the Commissioner, and agreement by the applicant and any other persons so designated that in the absence of actual malice, no communication made in response to any such inquiry will subject the persons making it to an action for damages for defamation brought by the applicant or the designated person or a legal representative of either. No such action shall lie whether such agreement is made or not.

Name of Applicant		
Name of President (Type or Print)	Signature of President	Date
Name of Secretary (Type or Print)	Signature of Secretary	Date

**BIOGRAPHICAL FORM A**  
(NAIC Biographical Form Acceptable)



State of Wisconsin  
Office of the Commissioner of Insurance  
125 South Webster Street  
P. O. Box 7873  
Madison, WI 53707-7873  
(608) 266-3585 • (800) 562-5558  
oci.wi.gov

Ref: ss. 617.11, 618.11, Wis. Stat.  
ss. Ins 6.52, ch. Ins 40, Wis. Adm. Code

---

STATEMENT OF EDUCATION, PRIOR OCCUPATION, BUSINESS EXPERIENCE, AND SUPPLEMENTARY INFORMATION

---

STATE OF \_\_\_\_\_ :  
COUNTY OF \_\_\_\_\_ :

The undersigned, being first duly sworn upon oath deposes and says:

1. The affiant's full name is (initials not acceptable):
  
2. Name of insurance company:
  
3. The affiant's official title and principal duties with the insurance company are or will be:
  
4. The affiant's business address is:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

5. The affiant's residence address is:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

6. The affiant's age is: \_\_\_\_\_ Birthplace: \_\_\_\_\_  
Sex: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Social Security No.: \_\_\_\_\_

7. The affiant was never known by any other name(s) other than that shown above, except as follows (state such other name(s), when used, reason for change, and date of adoption of present name):
  
8. The affiant will subscribe to or owns, beneficially or of record, the following amount of shares of stock of the insurance company and the consideration given for same:
  
8. The affiant states that his or her capital investment in the insurance company was not obtained from borrowed funds, except as follows:

9. The nature and tenure of each occupation or employment of the affiant for the last ten years prior to the date of this statement is as follows (present a continuous schedule, including time spent at educational institutions, and period of employment):

Beginning Date	Name and Address of Employer of School	Business Capacity or Title	Termination Date	Reasons for Termination

10. The affiant's educational history is as follows (include all schools attended of the college or graduate level):

Name and Address of Institution	Course	Attendance No. Years/Dates	Degree Received	Date of Degree

11. The affiant has never been convicted of a felony, except as follows:
12. The affiant has never been named in a criminal or civil action in which fraud was an issue, except as follows:
13. The affiant is not an officer or director and has no other relationship with any other insurer which has the effect of lessening competition substantially or in which such insurers have material adverse interests except as follows:

Subscribed and sworn before me, a Notary Public, this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

(SEAL)

My commission expires: \_\_\_\_\_

\_\_\_\_\_  
(Signature of Affiant)

\_\_\_\_\_  
Notary Public