TDI | Texas Department of Insurance

FIN527 | 0421

DISCOUNT HEALTH CARE PROGRAM OPERATOR REGISTRATION

All applicants read the General Information beginning on page 5.

The application must be either typed or printed in ink. All requested information must be submitted with this application.

Part I–To be completed by all applicants

Registration Type:

☐ Discount Healthcare Program Operator

Registration Fees: Fees are **$1000.00.** Make check or money order payable to the **Texas Department of Insurance. All Registration fees are nonrefundable and nontransferable.**

Entity Type: Check your entity type.

☐ Corporation ☐ Limited Partnership ☐ Limited Liability Company ☐ Sole Proprietorship
☐ Limited Liability Partnership ☐ Association ☐ Other ___________________________

Applicant Information: Please read carefully and provide all requested information.

1. **Operator's Full Legal Name:** ____
   PRINT FULL LEGAL NAME OF ENTITY (THE NAME MUST BE THE SAME AS ON THE OFFICIAL FORMATION DOCUMENT)

2. **All Assumed Names To be Used in Operating a Discount Health Care Program:**

   ____

   If a filing is required under the Assumed Business or Professional name Act pursuant to the Texas Business and Commerce Code, or any similar statute, the Discount Health Care Program Operator applicant for registration must provide the Texas Department of Insurance with a copy of the assumed name certificate reflecting the registration of each assumed name used by the discount health care program operator applicant.

3. **Applicant's Federal Employer Identification Number (FEIN) or Social Security Number and Phone Number:**
   This application cannot be processed without this information.

   ______________________ ______________________ __________
   FEIN/SSN DAYTIME PHONE NUMBER EXT

   ______________________ ______________________
   TOLL FREE PHONE NUMBER (###) ###-#### WEBSITE ADDRESS

4. **Contact Person:**

   ______________________ ______________________
   NAME TITLE

   ______________________ ______________________
   PHONE (###) ###-#### EMAIL ADDRESS (REQUIRED)

5. **Official Mailing Address:** *This is the address of record with TDI.*

   ____
   STREET, PHYSICAL LOCATION, ROUTE OR P.O. BOX

   ______________________ ______________________ ______________________
   CITY STATE ZIP CODE

6. **Business Address:** *This address must be your primary office address where the applicant will maintain business records of Texas transactions.*

BUSINESS ADDRESS (PHYSICAL LOCATION REQUIRED; P.O. BOX NOT ACCEPTED)

CITY STATE ZIP CODE

7. **Agent for Service:**

NAME

ADDRESS (PHYSICAL LOCATION REQUIRED; P.O. BOX NOT ACCEPTED)

CITY STATE ZIP CODE

8. **Statement:** Please provide a statement generally describing the applicant, its facilities and personnel, and the health care services or products for which a discount will be made available under its discount health care programs.

9. Provide the biographical information of the following individuals as explained in Part III:
   - **a.** The individual(s) responsible for conducting the program operator's affair's;
   - **b.** Each member of the board of directors;
   - **c.** Each member of the board of trusties;
   - **d.** Each member of the executive committee;
   - **e.** Each member of any other governing board or committee;
   - **f.** The officers of the program operator; and
   - **g.** Any contracted management company personnel; and
   - **h.** Any person owning or having the right to acquire 10% or more of the voting securities of the program operator.

Part II–Texas Authorizations and Financial Responsibility

1. **Business Authority in Texas:** Most entities are required to register with the Texas Secretary of State.
   - **a.** **All resident and nonresident** corporations, limited liability companies, limited partnerships, limited liability partnerships, and agricultural cooperatives must provide evidence of their authority to do business in the State of Texas by providing a copy of their Charter, Certificate of Authority, or registration that was obtained from the Texas Secretary of State's office. You may contact the Texas Secretary of State's office at **www.sos.state.tx.us** or call **512-463-5555**.
   - **b.** All banks and farm credit administration entities must provide a copy of the document issued by a federal or Texas state agency authorizing the entity to do business in Texas.
     Have you attached a copy of your document that authorizes the applicant to do business in Texas?
     ☐ No, not applicable because (i.e. general partnership) ☐ Yes
   - **c.** Franchise Taxes. Please be advised that a domestic or foreign entity doing business in the State of Texas may be subject to franchise reports and taxes as required by the Texas Tax Code, Chapter 171. For assistance or questions concerning compliance with filing franchise reports and taxes to remain in good standing with the State of Texas, you may visit the website of the Texas Comptroller of Public Accounts at **www.window.state.tx.us** or **call (800) 252-1381**.

2. **Financial Responsibility:** Attach an FIN525 Discount Health Care Program Operator Surety Bond Form in the principal amount of $50,000 in compliance with TIC §562.103(f).

Part III–Attachment Information:

1. **Biographical Certificates:** Attach a separate completed FIN526 Discount Health Care Program Operator Biographical Certificate form for:
   - **a.** The individual(s) responsible for conducting the program operator's affair's;
   - **b.** Each member of the board of directors;
   - **c.** Each member of the board of trusties;
   - **d.** Each member of the executive committee;
   - **e.** Each member of any other governing board or committee;
   - **f.** The officers of the program operator; and
   - **g.** Any contracted management company personnel; and
   - **h.** Any person owning or having the right to acquire 10% or more of the voting securities of the program operator.

   Surety Bond: Attach an FIN525 Discount Health Care Program Operator Surety Bond Form in the principal amount of $50,000 in compliance with Texas Insurance Code 562.103(f).

2. **Contracts:** Attach a copy of the form of all contracts made or to be made between the program operator and any providers or provider networks regarding the provision of health care services or products to members. After the initial registration, if the form of a contract changes the program operator must file the modified contract with the department before it may be used.

3. **List of Marketers:** Please provide a list of the marketers authorized to sell or distribute the program operator's program under the program operator's name, and a list of the marketing entities authorized to private label the program operator's programs. An updated list of marketers is due on March 31st, June 30th, September 30th and December 31st of each year.
   Please Email a copy of the completed FIN524 Discount Health Care Program Operator Marketers Form to the TDI email address: **TDI-DiscountHealth@tdi.texas.gov**.

4. **Mailing Instructions:** Mail this application, along with any fees and required attachments:

   Via **USPS** send to:

   MC: CO-AAL
   Agent and Adjuster Licensing
   Texas Department of Insurance
   PO Box 12030
   Austin, TX 78711-2030

   Via **UPS and Fedex** send to:

   MC: CO-AAL
   Agent and Adjuster Licensing
   Texas Department of Insurance
   1601 Congress Avenue, Suite 6.900
   Austin, TX 78701-1407

Your rights: You can request information we have about you by emailing OpenRecords@tdi.texas.gov or writing to: Public Information Coordinator, Texas Department of Insurance, PO Box 12030 (mail code GC-ORO) Austin, Texas 78711-2030. You also have the right to ask that we fix information we have about you that is wrong. To ask for a correction, send (1) your name, mailing address, and your phone number, (2) details about what needs to be fixed, and (3) the reason or proof showing why the information is wrong. Send this by email to RecordCorrections@tdi.texas.gov or by mail to: Record Correction Request, Texas Department of Insurance, PO Box 12030 (mail code CO-AAL-CC), Austin, Texas 78711-2030.

Part IV–Certification:

I hereby certify that I have personally and completely answered each of the questions herein and that the answers are true and correct to the best of my knowledge and belief, and that I have attached to this application all information requested. I further certify that I am aware of the provisions of the Texas Insurance Code and the rules and regulations promulgated by the Texas Department of Insurance, which relate to the issuance of the registration for which I am applying and the grounds under which such registration may be denied, suspended, revoked or non-renewed. I certify that the discount health care programs for which I am seeking registration as a discount health care program operator with the Texas Department of Insurance comply with the requirements of the Texas Insurance Code, Chapter 562 and Chapter 7001.

____
AUTHORIZED SIGNATURE

____
PRINT FULL LEGAL NAME

The State of ______________________________ , County of ______________________________,

Before me ______________________________, on this day personally appeared
(PRINTED NOTARY'S NAME)

______________________________, known to me (or proved to me
(PRINT NAME OF SIGNING INDIVIDUAL)

on the oath of ______________________________ or through ______________________________
(PRINTED NAME OF WITNESS KNOWN TO NOTARY PUBLIC) (DESCRIPTION OF IDENTITY CARD OR OTHER DOCUMENT)

to be the person whose name is subscribed to the foregoing instrument, and acknowledged to me that (s)he executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this ______________ day of ______________, A.D., __________.

(NOTARY SEAL)

____
NOTARY PUBLIC SIGNATURE

Notary Public, State of ______________________________

Part V–General Information:

Fees: A discount health care program operator is required to pay the Texas Department of Insurance an initial registration fee of **$1,000** as required by the Texas Insurance Code §7001.006. All application fees are nonrefundable and nontransferable. Make check or money order payable to the Texas Department of Insurance.

Names: Applicants must apply for registration in their full legal name as authorized on their official formation documents. If a filing is required under the Assumed Business or Professional name Act pursuant to the Texas Business and Commerce Code, or any similar statute, the discount health care program operator applicant for registration must provide the Texas Department of Insurance with a copy of the assumed name certificate reflecting the registration of each assumed name used by the discount health care program operator applicant.

Addresses: The official mailing address provided in Part I must be the discount health care program operator's permanent mailing address and is the address of record to which official correspondence, forms, notices and other information will be sent. Address changes must be reported to TDI as required in the Texas Insurance Code, § 7001.005. If the official mailing address changes, an applicant for registration or an applicant for renewal of registration must notify TDI, in writing, either by fax to 512-322-3553 or by mail to:

MC: CO-AAL
Agent and Adjuster Licensing
Texas Department of Insurance
PO Box 12030
Austin, TX 78711-2030

Biographical Form: The applicant for registration must submit a FIN526 Discount Health Care Program Operator Biographical Certificate to the Department for each of the individuals responsible for conducting the discount health care program affairs.

Fingerprinting: The fingerprint requirement is authorized in Texas Insurance Code §7001.008, §801.056.