



Employers ID No. _____

**APPLICATION FOR CERTIFICATE OF AUTHORITY
 TO DO BUSINESS IN THE STATE OF TEXAS**

 (Location of Books & Records) (Domestic Only)

 (Mailing Address)

 (City) (State) (Zip Code)

 (Office Phone) (Fax Number) (Toll Free Number)

 (Month) (Day) (Year)

TO THE COMMISSIONER OF INSURANCE OF THE STATE OF TEXAS:

On behalf of _____
 (Give name of Health Maintenance Organization in full)

whose home office is located at _____
 (Street Address of Incorporation)

in _____, _____
 (City of Incorporation) (State of Incorporation) (Zip Code)

we hereby apply for a certificate of authority authorizing said Health Maintenance Organization to be licensed as a Health Maintenance Organization in the State of Texas in compliance with the Texas HMO Act and the Rules and Regulations for Health Maintenance Organizations.

TYPE OF OWNERSHIP (Legal Entity)

- | | | | | | |
|-------------|-----|-------------|-------|------------|-----|
| Individual | () | Association | () | Profit | () |
| Partnership | () | Cooperative | () | Non-Profit | () |
| Corporation | () | Other | _____ | | |

We hereby certify that to the best of our knowledge and belief, the application of Certificate of Authority presented consists of all required by the Rules and Regulations governing Health Maintenance Organizations and is true, accurate and complete.

 Name

 Title

(Corporate Seal)

 Name

 Title