



Texas Department of Insurance

Life, Health & Licensing Program – Life, Health & HMO Intake Unit

Mail Code 106-1E, 333 Guadalupe • P. O. Box 149104, Austin, Texas 78714-9104
512-322-4245 telephone • 512-490-1017 fax • www.tdi.state.tx.us

TRANSMITTAL CHECKLIST FOR HMO FILINGS

HMO COMPANY NAME

CONTACT PERSON NAME/TELEPHONE/FAX

A. The following information is submitted for approval:

TYPE OF FORM	FORM NUMBER	NEW/REPLACEMENT
Evidence Of Coverage		
Service Area Description And Map		
Contracts With Any Person Listed On O&D Page, Any Exclusive Agency Contract Or Mgmt. Contract		
Change In Ownership Greater Than 10%		
Information Required By TIC §843.103 (Exercising Power With An Affiliate) Note: See 28 TAC §11.301(4)(E) And (G)		
Dividends Which Do Not Meet The Requirements Of 28 TAC §11.807		
Amendments To Bylaws		
Name, Assumed Name, Service Mark Or Trademark		
Agreement With Affiliate To Handle HMO's Investment Under 28 TAC §11.804		
Access Plans. See 28 TAC §11.1607		
Other		

B. The following information is submitted for informational purposes only:

TYPE OF FORM	FORM NUMBER	NEW/REPLACEMENT
List of officers and directors and biographical affidavit		
Cancellation, new or amendment to bond on officers/directors		
Formula or method of calculating the schedule of charges (form #6 attached)		
Change in administrative offices		
Domiciliary states' COA and power of attorney (foreign)		
Contracts or subcontracts with physicians and providers*		
Member handbook. See 28 TAC §11.301(5)(K)		
Stop loss or reinsurance agreement, if changing description of coverage		
Change in affiliate Chart		
Other		

***NOTE:** EACH COPY OF THE AMENDED CONTRACTS MUST BE "RED-LINED" TO INDICATE THE REVISIONS.

CERTIFICATION

I, _____ do hereby certify that I am an officer of _____
(printed name) (name of HMO)

with the title of _____.
(title)

I certify that I have personal knowledge of the form(s) submitted and do certify that the final printed form(s) will be the exact same language, without variation, as the approved forms and that I am familiar with the statues, roles and regulations governing HMOs, and that I have personal knowledge of the items submitted on the behalf of

(Name of HMO)

I further certify under penalty of applicable law that the items listed above are attached. I further certify that those items are true, accurate and complete and comply with all statutes, rules and regulations governing HMOs.

(Signature)