"Strengthening competitive insurance markets while protecting Alaskans."

STATE OF ALASKA

DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC DEVELOPMENT

Division of Insurance

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HEALTH DISCOUNT PLAN REGISTRATION

PART 1 Registration Type

Application is hereby made to the Director of Insurance for Registration for a Health Discount Plan:

Registration Type: ☐ Original ☐ Renewal ☐ Amendment

PART 2 Entity Information

Legal Name (if amending name, indicate former name)**:**	
DBA (if any)**:**	
State of Domicile:	**FEIN:**
Principal Place of Business in State of Domicile:	
Principal Place of Business in Alaska:	
Physical Address:	
Mailing Address, if different from Physical Address:	
Name of Contact:	**Position:**
Contact Mailing Address:	
Phone:	**Fax:**
Email:	**Website:**

PART 3 Required Attachments

The Following Items Must be Attached to this Form:

- ☐ Copy of all in-force or proposed health discount plan forms for use in Alaska

PART 4 Voluntary Attachments

The Following Items May be Attached to this Form:

- ☐ List of states where applicant is authorized to offer Health Discount Plans
- ☐ Copy of Alaska Business License
- ☐ Description of the proposed marketing methods (internet, telephone, email, etc.)

PART 5 Certification (must be signed by an officer of the applicant)

The undersigned provider, through its authorized representative, applies for Registration under AS 21.36.505. I hereby certify to the best of my knowledge and under penalty of perjury that I am a senior officer of the health discount plan; I am authorized to sign the application on behalf of the health discount plan; I have read the application and have personal knowledge of the information provided therein; the information contained in this application and all necessary attachments forming part of the application are true and correct; and the arrangement is in compliance with AS 21.36.505. A person commits the crime of unsworn falsification in the second degree if, with the intent to mislead a public servant in the performance of a duty, the person submits a false written or recorded statement that the person does not believe to be true.

The undersigned provider certifies that it will comply with all present and future laws of the State of Alaska regarding regulation of Health Discount Plans.

Printed Name of Officer Signing Application:

Title and Position of Officer Signing Application:

Officer's Signature: