



National Association of Insurance Commissioners

# COMPANY CODE APPLICATION

PLEASE PRINT CLEARLY AND IN BLOCK LETTERS. **RISK-BEARING ENTITIES**

**YOUR APPLICATION WILL NOT BE PROCESSED UNLESS YOU HAVE BEEN ISSUED A LICENSE BY THE STATE INSURANCE DEPARTMENT IN THE STATE YOU ARE APPLYING FOR.**

**\*\*Please include a copy of your current financial statements with this application\*\***

FULL COMPANY NAME

FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN)

STATE OF DOMICILE

DATE COMMENCED BUSINESS

DATE OF ORGANIZATION/INCORPORATION

MAIN ADMINISTRATIVE OFFICE ADDRESS

CITY

STATE

ZIP

PHONE

CURRENT FINANCIAL STATEMENT CONTACT PERSON

EMAIL ADDRESS

CURRENT FINANCIAL STATEMENT ADDRESS

CITY

STATE

ZIP

PHONE

COMPANY PRESIDENT

SELECT YOUR BUSINESS TYPE:

- Fraternal
- Life, Accident & Health
- Title
- Health
- Property & Casualty
- Other Real Estate Entity

SELECT YOUR BUSINESS SUB-TYPE:

- Hospital, Medical, and Dental Service or Indemnity (HMDI)
- Prepaid Legal
- Health Maintenance Organization (HMO)
- Prepaid Health
- Limited Health Services Organization (LHSO)
- Prepaid Health Plan
- Other Health Plan
- None

SELECT YOUR COMPANY TYPE:

- Stock
- Limited Liability Corporation
- Reciprocal
- U.S. Branch of Alien Insurer
- Cooperative
- Charitable Gift Annuity
- Other

SELECT YOUR COMPANY SUB-TYPE:

- Residual Market Mechanisms
- State Insurance Fund/Program
- Risk Retention Group – Captive
- Captive – Pure
- Risk Retention Group – Traditional
- Captive – Other
- Special Purpose Vehicle
- Manager Managed Limited Liability Company
- City, Town, County, State, Parish, Township Mutual
- None

TAX STATUS:

- Subject to IRS Tax
- IRS Tax Exempt (with exceptions)

IS THIS OUT OF STATE?  Yes  No

IS THIS A U.S. BRANCH OF AN ALIEN INSURER?  Yes  No If **YES**, what state is your port of Entry? \_\_\_\_\_

CHECK BELOW WHICH PERIOD YOU WILL BE SUBMITTING YOUR FIRST STATEMENT FILING?  Annual  Quarter 1  Quarter 2  Quarter 3 YEAR \_\_\_\_\_

SELECT THE TYPE OF ANNUAL STATEMENT BLANK YOU WILL BE FILING

Combined Property & Casualty  Fraternal  Not Required to File  
 Individual Property & Casualty  Health  
 Life, Accident and Health  Title

If filing a **LIFE** or **FRATERNAL** statement, are there any separate accounts to report? If **YES**, please list the names below:

_____	FOR OFFICE USE ONLY	SEPA ID _____
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**< C @ - B ; ' 7 C A D 5 B M 5 B 8 ' AFFILIATION REPORTING SECTION**

HOLDING COMPANY  Part of an Ultimate Holding Company System  Not Part of an Ultimate Holding Company System

Is this company affiliated with or reported on another domestic Insurance entity's organizational chart?  Yes  No

If **YES**, and a group code **HAS** already been established, please list below your group code and group name.

If **YES**, and a group code **HAS NOT** been established, one will be established for you. Please list below the affiliated domestic insurance companies, including their company codes. Also enclose a current copy of your Organizational Chart or Schedule Y with this application.

GROUP CODE	GROUP NAME
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LIST AFFILIATED COMPANIES AND COMPANY CODES

NAME AND TITLE OF PERSON COMPLETING THIS APPLICATION	EMAIL ADDRESS
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**Submit your application via email or fax. Once received, your new NAIC Company Code confirmation will be emailed within 4 business days to the Current Financial Statement Contact, as well as to the person completing this application, if different.**

**For additional questions:**

<p>Jennifer Heinz  Data Administrator III, Data Services  Direct Phone: <b>(816) 783-8605</b>  Fax: (816) 460-0131  Email: FDRCCREQ@NAIC.ORG</p>	<p>Cheryl Minor  Data Administrator III, Data Services  Direct Phone: <b>(816) 783-8608</b>  Fax: (816) 460-0131  Email: FDRCCREQ@NAIC.ORG</p>
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Application last updated: 1/1F/201H