



**Financial Affairs Division
Arizona Department of Insurance**

100 North 15th Avenue, Suite 102, Phoenix, Arizona 85007-2624
 Phone: (602) 364-3999
 Web: <https://insurance.az.gov/>

Life Care Provider Annual Report Filing Checklist

Attach this Checklist on top of your Annual Report Form E-Lifecare

Enter the information for the Life Care Provider and Manager (if applicable) below:

NAIC Number: _____ **OR** Arizona Company Number: _____ Federal I.D. No: _____

Life Care Provider Name: _____ Fiscal Year Ends: _____
 Month/Day

Facility/DBA Name: _____

Manager Name: _____ Fiscal Year Ends: _____
 Month/Day

Financial Statement "As of" Date / /
mo. / day / year

Initial if Completed & Enclosed ↓↓↓	Initial at left if items are included with Annual Report Form E-LIFECARE	Agency Use Only ↓↓↓
	A. \$450.00 Filing Fee – <u>check</u> payable to Arizona Department of Insurance <u>is enclosed.</u>	
	B. Title Page (Page 1 of 12) is complete for all information	
	C. Chief Executive Officer Name, Title and Signature on Page 1	
	D. Notarization of Chief Executive Officer Signature on Page 1	
	E. Preparer's Name, Title, Phone and E-mail address on Page 1	
	F. Pages 2 through 11, Complete responses to Items 1 through 13	
	G. Page 3, Exhibit 1 - Copy of Life Care Contract	
**	H. Page 4, Exhibit 2 - Arizona Biographical Affidavit Form E110 for each officer, director, trustee or managing partner that has not filed an original Bio within the last 3 years. **Enter "N/A" in box if ALL required Bio's have been within the last 3 years → <input type="text"/>	
**	I. Page 12, Exhibit 3 - Certified Financial Statement(s) for the 2 most recent fiscal years of the: 1. Provider 2. Manager , if applicable. **Enter "N/A" in box if not applicable → <input type="text"/> 3. Promoter , if applicable. **Enter "N/A" in box if not applicable → <input type="text"/>	
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**	J. Page 12, Exhibit 4 - Actuarial Study , if applicable. **Enter date last filed if not enclosed <input type="text"/>	
	K. Page 12, Exhibit 5 - Copies of Escrow Agreements.	

Preparer's Name _____ Title _____

Telephone Number _____ Email Address _____