Reset

ARIZONA

DEPARTMENT OF
INSURANCE AND FINANCIAL INSTITUTIONS

APPLICATION FOR LIFE CARE PROVIDER PERMIT CHANGE

Provider Name _____ Employer's ID Number _____

State of Domicile _____, Date Incorporated/Organized _____, Type of Entity _____

Home Office _____ (Street and Number), _____ (City, State and Zip Code)

_____ (Telephone Number), _____ (Fax Number)

Administrative/Mail _____ (Street and Number), _____ (City, State and Zip Code)

_____ (Post Office Box), _____ (City, State and Zip Code)

_____ (Telephone Number), _____ (Fax Number)

Facility Name _____

Facility Address _____ (Street and Number), _____ (City, State and Zip Code)

Number of: _____ (Living Units) _____ (Assisted Living Units) _____ (Health Care Beds) _____ (Contract Holders)

Contact Person _____ (Name), _____ (Title)

_____ (Telephone Number), _____ (Email Address)

Provider hereby applies for an amended Permit in accordance with the provisions of Arizona Revised Statutes, Title 20, Chapter 8, Article 1 due to change of the Provider's _____.

As a condition precedent to and as a consideration for the issuance of the Permit to enter into life care contracts herein applied for, this Provider declares that it has complied with all laws of the state of domicile relating to such companies, and that it accepts the terms and provisions of the laws of the State of Arizona applicable to said Provider.

I certify that I have reviewed this Application. It is true, complete and correct to the best of my knowledge and belief.

Dated at _____ this _____ day of _____, _____

_____ Signature of Chief Executive Officer

_____ Title