NEVADA DIVISION OF INSURANCE

STATE SPECIFIC REQUIREMENTS
MEDICAL DISCOUNT PLAN APPLICATION CHECKLIST
CERTIFICATE OF REGISTRATION NRS 695H

Date:
Name of Applicant:
NV ID:
FEIN:
Principal Address:
Phone:
Email:

The following checklist pertains to a MEDICAL DISCOUNT PLAN who wishes to operate in the State of Nevada. The Nevada Division of Insurance ("Division") requires the following items in order to process your application. Failure to provide any of the items listed below will delay the review of your application. Please note, until all of the items listed below have been received and reviewed by the Division, you may not operate, solicit or otherwise transact insurance in Nevada. Upon completion of our review, you will receive written notice, along with a Certificate of Registration, allowing you to transact business in Nevada.

- ✓ **Pursuant to NRS 695H.080 an insurer is not required to register any medical discount plan unless the insurer offers, markets or sells the medical discount plan in Nevada for separate consideration.**
- ✓ **Pursuant to NRS 695H.090(3) An administrator or insurer that registers a medical discount plan is not required to pay the fees for registering or renewing the registration of the medical discount plan pursuant to this section.**
- ✓ **The administrator or insurer is, however, required to pay the Fund for Insurance Administration & Enforcement fee of $1,300 to register, and $1,300 to annually renew the registration.** Invoices will be mailed in January.
- ✓ **The Certificate of Registration does not allow the Medical Discount Plan to market or administer products which are not approved in Nevada, or which are issued by a non-admitted insurer or unauthorized multiple employer trust or associated marketing plan.**

1. Attach a letter or notice of anticipated operations in Nevada.
2. Attach a copy of Articles of Incorporation, certified by the Secretary of State, Bylaws and Partnership Agreement (if applicable).
3. Attach Certificates of Registration or License Status (aka Certification Letters).

Please indicate the status of any application, license or registration you have or have applied for in the table below.

AF	APPLIED FOR	AA	APPROVED	NA	NOT APPLICABLE	NR	NOT REQ'D TO REGISTER/LICENSE
R	REGISTERED	D	DENIED	L	LICENSED	P	PENDING

AK		FL		KY		MT		OH		TX	
AL		GA		LA		NC		OK		UT	
AR		GU		MA		ND		OR		VA	
AZ		HI		MD		NE		PA		VI	

CA		IA		ME		NH		PR		VT	
CO		ID		MI		NJ		RI		WA	
CT		IL		MN		NM		SC		WI	
DC		IN		MO		NV		SD		WY	
DE		KS		MS		NY		TN			

4. Attach the most recent audited financial statements as prepared by an independent certified public accountant. If the audited financial report is more than 6 months old, include:
   An income statement, balance sheet and cash flow statement for the 90-days immediately preceding the date the application was filed with the Division, prepared in accordance with generally accepted accounting principles.
   -Or-
   If current audited financial statements are not available, include an income statement, balance sheet and cash flow statement for the 2 years immediately preceding the application, prepared in accordance with generally accepted accounting principles and certified by an independent certified public accountant.
5. Attach a list of, and biographical affidavits of, each person who is responsible for conducting the business activities of the medical discount plan of the applicant, including, but not limited to, all members of the board of directors, board of trustees, officers and managers. The list must set forth the extent and nature of any contracts or other agreements between any person who is responsible for conducting the business activities of the applicant and the medical discount plan, including disclosure of any possible conflicts of interest. The forms are available from the NAIC Web site at: http://www.naic.org/documents/industry_ucaa_form11.doc
6. Is the applicant an insurer?
7. Is the applicant administered or backed by an insurer?
8. Attach an org chart showing the applicant and upstream entities.
9. State of domicile.
10. Principal place of business.
11. State of domicile of the insurer and date of charte.r
12. Attach a copy of all marketing materials and a description of the method of marketing proposed by the applicant
13. Attach a copy of all forms used for contracts between the applicant and networks of providers of health care regarding the provision of health care or medical services to members.
14. Attach a description of the procedures for making a complaint to be established and maintained by the applicant.
15. Attach a copy of provider/reseller lists.
16. A summary discussion acknowledging the requirements of NRS 695H.100 – usage of certain insurance terms, and NRS 695H.110 - .120, disclosures and font sizes.
17. A description of the procedures for a plan member to register a complaint; how and where the complaint data will be stored, and acknowledgement that the data must be accessible to the Division for the purposes of compliance and consumer satisfaction.
18. Identify all other states in which the group intends to do business.
19. Attach an original letter from domiciliary state certifying that the MDP is properly registered.
20. Attach an original letter of certification for each state in which the MDP is licensed or registered. Certifications should be in alpha order by state and should not be over 90 days old.
21. A minimum net worth of $100,000 must be maintained at all times. Failure to maintain the minimum net worth will constitute a violation of NRS 695H and NAC 695H, and subject the applicant or registrant to administrative actions.
22. Application fees (**NRS 680C.110 Fees**).

a) Application Fee	$500	Annual Renewal	$500
b) Review Fee	$500		
c) Service of Process	$5		
d) Fund for Insurance Admin & Enforcement	$1,300	Annual Renewal	$1,300

NRS 695H.090 Annual filing requirements to continue doing business in Nevada. Invoices will be mailed in January.

An incomplete application will only be held, pending completion, for 90 days following first receipt. If the application has not been completed within 90 days of the Division's receipt of the first application, it will be rejected. The applicant may submit a new application and fee.

The Division will give notice to the applicant as to why the application is "incomplete" and request additional information. The applicant must submit the information within 90 days of the Division's first receipt. If the applicant fails to submit the information requested within the allotted time, the application is considered "incomplete" and will be rejected.

The applicant may "withdraw" the application within the initial 90 days if the application is "incomplete". The withdrawn application would not be considered as "rejected" or "denied."

NRS 695H.050 "Medical discount plan" means a business arrangement or program evidenced by a membership agreement, contract, card, certificate, device or mechanism in which a person, in exchange for fees, dues, charges or any other form of consideration, offers to provide or provides health care or medical services at a discount from providers of health care who are participating in the business arrangement or program or whom the person advertises as or claims to be participating in the business arrangement or program.

NRS 695H.070 Medical discount plans under exclusive jurisdiction of Commissioner. Notwithstanding any other provision of law, the Commissioner has exclusive jurisdiction to regulate medical discount plans in Nevada.

NRS 695H.080 Registration of medical discount plan required; exceptions.

1. Except as otherwise provided in this section, it is unlawful for any person to offer, market, sell or engage in business as a medical discount plan in this State without first registering the medical discount plan pursuant to the provisions of this chapter.
2. An insurer is not required to register any medical discount plan pursuant to the provisions of this chapter unless the insurer offers, markets or sells the medical discount plan in this State for separate consideration.
3. If an affiliate of an insurer offers, markets, sells or engages in business as a medical discount plan in this State, the affiliate is required to register the medical discount plan pursuant to the provisions of this chapter.
4. The provisions of this chapter do not apply to any medical discount plan that offers or provides discounts only on prescriptions.

Resident Corporations, Limited Liability Companies, Limited Liability Partnerships and Associations: The Articles of Incorporation/Organization must be approved by the Division prior to the filing the Articles of Incorporation/Organization with the Nevada Secretary of State ("SoS"). Please contact the SoS for the applicable fees at (775) 684-5708 or http://www.sos.state.nv.us.

1. The purpose of the Articles of Incorporation must include, "Medical Discount Plan".
2. Completed Articles of Incorporation/Organization must be provided to the Division for name and purpose approval.
3. If the Articles are approved, the Division will forward the Articles of Incorporation/Organization to the SoS, for approval.
4. Any business entity that fails to maintain its qualification with the SoS, forfeits its right to do business in this state and must immediately surrender any licenses issued by this Division.

Nonresident Corporations, Limited Liability Companies, Limited Liability Partnerships and Associations must file their Articles of Incorporation/ Organization with the Nevada Secretary of State. Please contact the Nevada Secretary of State for the applicable fees at (775) 684-5708 or http://www.sos.state.nv.us.

1. The purpose of the Articles of Incorporation must include "Medical Discount Plan".
2. The Articles of Incorporation/Organization and any fees payable must be submitted directly to the SoS.
3. Approved Articles of Incorporation/Organization must be submitted to the Division with this application.
4. Any business entity that fails to maintain its qualification with the SoS forfeits its right to do business in this state and must immediately surrender any licenses issued by this Division.

Please refer any questions to loconnor@doi.nv.gov (775) 687-0745

Submit the above information via UCAA electronic means (preferred), CD or flash drive to:

Nevada Division of Insurance
Laura O'Connor C&F
1818 E. College Parkway, Suite 103
Carson City, NV 89706

Send payment to the Nevada Division of Insurance via ACH or Check

- ACH - MUST submit ACH Deposit Form at time of payment
- Check - Submit remittance advice with your check if paying an invoice; otherwise note "Application Fees" on the check

Department of Business and Industry

Nevada Division of Insurance

1818 E. College Pkwy, Suite 103, Carson City, Nevada 89706 **Phone:** (775) 687-0700 **Fax:** (775) 687-0787

Change of Address Form

Questions: Call (775) 687-0761 Email completed form to rbeaver@doi.nv.gov

Nevada ID Number | NAIC Number | NAIC Group Code

FEIN Number | State of Domicile

Company Name | Company Contact Name | Company Email

Company Web Address | Company Phone Number | Company Fax Number

Statutory Home Office
Do not include branch offices

Contact/Title | Street Address | City, State, Zip

Address to receive correspondence
Used to receive correspondence including letters, information, billing notices, assessments and hearing notices for companies holding Certificates of Authority, Certificates of Registration, Certificates of License, Certificates of Approval or Letters of Approval

Contact/Title | Phone | Mailing Address Contact E-mail

Street Address/PO Box | City, State, Zip

Address to receive renewal invoices
Used to receive annual renewal invoices for insurers (not appointment renewals)

Contact/Title | Phone | Renewals Contact E-mail

Street Address/PO Box | City, State, Zip

Must be signed by a principal officer of the company

Name/Title of Principal Officer | ☐ I attest that this is my electronic signature | Date of Signature

NEVADA DIVISION OF INSURANCE

APPOINTMENT DESIGNATION FOR SERVICE OF PROCESS

MEDICAL DISCOUNT PLAN

NRS 695H

Date:
Name of Applicant:
Applicant Home Office Address:
NV ID:
NAIC:

DESIGNATED INDIVIDUAL WHO WILL ACCEPT SERVICE OF PROCESS FORWARDED BY THE COMMISSIONER OF INSURANCE

Individual Name:
Address:

Dated this day of , 201

OFFICER CERTIFICATION AND ATTESTATION

Name of Company Officer

☐ *I attest that this is my true electronic signature*

☐ *I acknowledge that I am authorized to execute this document on behalf of the Applicant.*

☐ *I hereby certify under penalty of perjury under the laws of the applicable jurisdictions that all of the forgoing is true and correct.*

The entity named above agrees to submit an amended Appointment for Service of Process form upon a change in any of the information provided herein.