



Department of Consumer & Business Services

Insurance Division – 4

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insurance.oregon.gov

**Discount Medical Plan
Organization Renewal**

1. Federal identification number or IRS taxpayer identification number: _____
2. Name of applicant: _____
3. Assumed business name (if applicable): _____
4. Other identities (if applicable): _____
5. Street address: _____
City: _____ State: _____ ZIP: _____
6. Mailing address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ - _____ - _____ Fax: _____ - _____ - _____ E-mail: _____
7. Principal business address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ - _____ - _____ Fax: _____ - _____ - _____ E-mail: _____
8. Organization Web site address: _____
9. Toll-free number for member assistance: _____
10. Contact person: _____
Phone: _____ - _____ - _____ Fax: _____ - _____ - _____ E-mail: _____
11. Domicile: _____
12. The name of and contact information for a person that the applicant has designated to provide information to consumers or answer consumer questions:

13. During the past year has there been any changes in another jurisdiction? Yes No
If yes, please describe: _____

I, _____ certify that I am an officer of the organization named in the foregoing application, that I know the contents thereof, and each of the statements and answers made is true and complete to the best of my knowledge and belief. Further, the organization submits to the jurisdiction of any court of competent jurisdiction in Oregon for the adjudication of any issues arising out of its discount medical plans, agrees to comply with all requirements necessary to give such court jurisdiction, and will abide by the final decision of such court or any appellate court in the event of an appeal.

Date

Signature