



National Association of Insurance Commissioners

COMPANY CODE APPLICATION

YOUR APPLICATION WILL NOT BE PROCESSED UNLESS YOU HAVE BEEN ISSUED A CERTIFICATE OF AUTHORITY BY THE STATE INSURANCE DEPARTMENT IN WHICH YOU ARE DOMICILED.

****Please include a copy to this pdf application.****

FULL COMPANY NAME

FEDERAL EMPLOYERS IDENTIFICATION NUMBER (FEIN)	STATE OF DOMICILE	DATE COMMENCED BUSINESS	DATE OF ORGANIZATION/INCORPORATION
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MAIN ADMINISTRATIVE OFFICE ADDRESS

CITY	STATE	ZIP	PHONE
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CURRENT FINANCIAL STATEMENT CONTACT PERSON	EMAIL ADDRESS
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CURRENT FINANCIAL STATEMENT ADDRESS

CITY	STATE	ZIP	PHONE
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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)
- None
- Limited Health Services Organization (LHSO)

SELECT YOUR COMPANY TYPE:

- Stock
- Limited Liability Corporation
- Reciprocal
- US Branch of Alien Insurer
- Cooperative
- Charitable Gift Annuity
- Other

SELECT YOUR COMPANY SUB-TYPES:

- 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)

SELECT THE TYPE OF ANNUAL STATEMENT BLANK YOU WILL BE FILING.

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

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

<p>_____</p> <p>_____</p>	<p>FOR OFFICE USE ONLY</p>	<p>SEPA ID</p>	<p>_____</p> <p>_____</p>
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CHECK BELOW WHICH PERIOD YOU WILL BE SUBMITTING YOUR FIRST STATEMENT FILING?

- Annual
- Quarter 1
- Quarter 2
- Quarter 3
- YEAR _____

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

AFFILIATION REPORTING SECTION

HOLDING COMPANY LISTING

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 e-mailed 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: (816) 783-8605 Fax: (816) 460-0131 E-Mail: FDRCCREQ@NAIC.ORG</p>	<p>Cheryl Minor Data Administrator III, Data Services Direct Phone: (816) 783-8608 Fax: (816) 460-0131 E-Mail: FDRCCREQ@NAIC.ORG</p>
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