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Official Use Only:
Fee: _____
App: _____
No.: _____

**DISCOUNT MEDICAL PLAN AND DISCOUNT DRUG PLAN
 REGISTRATION APPLICATION**

This Application Form is required for Discount Medical Plan and/or Discount Drug Plan Registration pursuant to Title 14, Subtitle 6 of the Insurance Article, Annotated Code of Maryland.

Section 1a - Application Information (check applicable items)

This Application is for the registration of a (check one):	<input type="checkbox"/> Discount Medical Plan Organization Only	<input type="checkbox"/> Discount Drug Plan Organization Only	<input type="checkbox"/> Discount Medical Plan and Discount Drug Plan Organization	
Check either "Initial" or "Renewal" Application and "Domestic Business Entity", if applicable:	<input type="checkbox"/> Initial Registration Application	<input type="checkbox"/> Renewal Registration Application	<input type="checkbox"/> Domestic (Maryland) Business Entity	
If Applicant is a Corporation or Limited Liability Company (LLC), it attests that is registered and in good standing with the Maryland Department of Assessment and Taxation, as of this date of application.			<input type="checkbox"/> Yes	<input type="checkbox"/> No

Section 1b - Applicant (Business Entity) Information

1. Applicant Name (Business Entity name)				
2. DBA/Trade Name (If other than Business Entity name)			3. FEIN Number	
4. Business Address (Physical Location)		5. City		6. State
		7. Zip		
8. Business Phone Number	9. Business Fax Number	10. Business Web Site		

Section 1c – Applicant Primary Contact Information (Officer, Owner, Partner, Director or Board Member)

12. Primary Contact First Name	13. Contact M.I.	14. Primary Contact Last Name	15. Suffix	16. Social Security Number
17. Title	18. Business Phone Number	19. Business E-mail Address		
20. Mailing Address (if other than provided in Section 1)		21. City	22. State	23. Zip

Section 1d – Contact Information for Agent for Service of Process appointed by Applicant (if applicable)

35. Contact First Name or Firm Name	36. Contact M.I.	37. Contact Last Name	38. Suffix	39. SSN or FEIN
40. Title	41. Business Phone Number	42. Business E-mail Address		
43. Mailing Address (if other than provided in Section 1)		44. City	45. State	46. Zip

Section 4 – Nominal Fee

Pursuant to Code of Maryland Regulations (COMAR) 31.10.24, Discount Medical Plan Organizations and/or Discount Drug Plan Organizations may not retain a nominal fee when a consumer cancels membership within 30 days of enrollment unless the nominal fee amount has been filed with the Maryland Insurance Commissioner. Applicants may file the nominal fee with this Application by providing the following information: (1) the amount of the nominal fee; and (2) the actual expenses incurred for issuing a discount plan card including the cost of creating the card and mailing it to the member. Explanation of actual expenses incurred may be included as an attachment.

1. Nominal Fee Amount:	2. Actual Expenses Incurred
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Section 5 – Applicant Certification and/or Attestation

As the Applicant or as the authorized representative of the business entity Applicant, I hereby certify under penalty of perjury, that:

- (a) All of the information submitted in this application and attachments is true and complete. I am aware that submitting false information or omitting pertinent or material information in connection with this application is grounds for revocation or denial of registration and may subject me to civil or criminal penalties.
- (b) Permission is granted to the State of Maryland Insurance Commissioner or his designated representative to verify information with any federal, state or local government agency, current or former employer, or insurance company.
- (c) The State of Maryland Insurance Commissioner or his designated representative is authorized to give any information concerning me, as permitted by law, to any federal, state or municipal agency, or any other organization and I release the jurisdictions and any person acting on their behalf from any and all liability of whatever nature by reason of furnishing such information.
- (d) All Discount Medical Plan and/or Discount Drug Plan disclosures, forms, membership cards, brochures, advertising and contracts used will comply with insurance laws and regulations of the State of Maryland and contain the required information.
- (e) Applicant shall file all reports required by the Insurance Commissioner including information on persons authorized to sell, market or solicit a Discount Medical Plan and/or Discount Drug Plan in the State of Maryland.
- (f) Applicant understands and will comply with the insurance laws and regulations of the State of Maryland to which application for registration is hereby made:

_____	_____
Signature	Date
_____	_____
Full Typed or Printed Name of Signer	Title

Section 6 – Attachments

Information needed in response or in supplement to other sections of the Application must be included as attachments to complete the Application. Failure to provide the required Attachments may result in the Application being returned unprocessed or considered deficient. Each Attachment page must include an original signature of the Applicant or its authorized representative along with the Applicant's identifying SSN or FEIN.

Section 7 – Applicant Registration Fee

For Initial Registration: Applicant shall pay a non-refundable fee to the Maryland Insurance Administration in the amount of \$250. Registration expires on the second June 30 following registration unless it is renewed. Before a registration expires, it may be renewed for an additional 2-year term.

For Registration Renewal: Registrant shall pay a non-refundable fee to the Maryland Insurance Administration in the amount of \$150. An application for renewal of registration shall be considered made in a timely manner if it is postmarked or otherwise submitted on or before June 30 of the year of renewal.

All fees should be made payable to the **Maryland Insurance Administration** by check or money order.