



Continuing Care Retirement Community (CCRC) Application for Certificate of Authority to do Business in the State of Texas under the Act, §246.022 (CCRC Form #1)

(Name of Provider)

(Complete Mailing Address of Provider)

(Date)

TO THE COMMISSIONER OF INSURANCE OF THE STATE OF TEXAS:

On behalf of (Full Legal Name of Provider)

doing business as (dba) (Name of Facility)

which facility is located at (Street Address)

in (City) (State) (Zip Code)

We hereby apply for a certificate of authority authorizing provider of said facility to be licensed as a Continuing Care Facility in the State of Texas in compliance with Section 246.022 of the Health and Safety Code and the Rules promulgated by the State Board of Insurance.

TYPE OF CORPORATION

Profit ( ) Non-Profit ( )

Federal Employer ID Number

CONTROL OF THE PROVIDER

List the person(s) who possess control, directly or indirectly, through one of the following:

- (1) The power to direct or cause the direction of the management and policies of the Provider.
- (2) Owns, controls, holds with the power to vote or holds irrevocable proxies representing 10 percent or more of the voting securities or authority of the provider.

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(If additional space is needed, please attach separate page.)

Any questions concerning this application should be directed to:

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(Name)

at \_\_\_\_\_

(Complete Mailing Address) (Phone Number)

The Filing Fee of \$ \_\_\_\_\_ is enclosed.

We \_\_\_\_\_ as \_\_\_\_\_ and  
 (Corporate Officer) (Title)  
 \_\_\_\_\_ as \_\_\_\_\_ of  
 (Corporate Officer) (Title)  
 \_\_\_\_\_ do  
 (Provider)

hereby certify that to the best of our knowledge and belief, the application for certificate of authority presented consists of all items required by the Rules governing said facility and is true, accurate, and complete.

(Corporate Seal)

\_\_\_\_\_  
 (Officer's Signature) \*

\_\_\_\_\_  
 (Officer's Signature) \*

STATE OF

COUNTY OF

Subscribed and sworn to be the said affiants on the \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_

(Notary Seal)

\_\_\_\_\_  
 Signature of Notary

My Commission Expires:

\_\_\_\_\_  
 Notary's Printed Name

\*Must be signed by appropriate officers of Provider.

*INCOMPLETE APPLICATIONS IMPEDE TIMELY REVIEW BY THE DEPARTMENT; THEREFORE, IT IS EXTREMELY IMPORTANT THAT APPLICATIONS ARE COMPLETE. Submit a complete filing to the Texas Department of Insurance, Company Licensing & Registration, MC 103-CL, P.O. Box 149104, Austin, TX 78714-9104. For questions or more information, call (512) 676-6375.*

*THESE GUIDELINES ARE GENERAL IN NATURE AND DO NOT SUPERCEDE STATUTE OR REGULATION. THEY ARE NOT INTENDED TO BE ALL INCLUSIVE AND ADDITIONAL DOCUMENTATION MAY BE REQUESTED.*