



**STATE OF SOUTH CAROLINA  
DEPARTMENT OF CONSUMER AFFAIRS**



**Mailing Address**  
P.O. Box 5757  
Columbia, SC 29250-5757

**DISCOUNT MEDICAL PLAN ORGANIZATIONS**

S.C. Code Ann. § 37-17-10 *et seq.*  
[www.consumer.sc.gov](http://www.consumer.sc.gov)  
(803) 734-4200

**Street Address**  
2221 Devine St. Suite 200  
Columbia, SC 29205

**RENEWAL APPLICATION  
FOR  
DISCOUNT MEDICAL PLAN ORGANIZATION  
REGISTRATION**

(Complete all parts of this Application)

**Please submit an original of the Application in ring binders. All information should be reduced to 8½ x 11 size and arranged with tab inserts numbered accordingly in the order set forth in the Application form.**

Name of  
DMPO: \_\_\_\_\_

Registration Certificates for Discount Medical Plan Organizations (DMPOs) in South Carolina are issued annually. The registration period runs from February 1 until January 31 of the following year, and the annual renewal period begins January 1 and ends on January 31 each year. A discount medical plan organization that files its renewal on a timely basis may continue operating unless the registration is denied or revoked by the department.

The annual application fee must accompany each application and is NOT refundable. The fee for a DMPO with 0-50 representatives is Five Hundred Dollars (\$500.00). The fee for a DMPO with 51-100 representatives is Seven Hundred Fifty Dollars (\$750.00). The fee for a DMPO with over 100 representatives is One Thousand Dollars (\$1000.00). **Applications will not be processed without the required applications fees.**

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 Department's receipt of the first application, it will be rejected. The applicant, if it chooses, may submit a new application and fee. The Department will give notice to the applicant as to why the application is "incomplete" and request additional information. The applicant must submit the information (to complete the application) within 90 days of the Department's first receipt. If the applicant fails to submit the information requested within the allotted time, the application is deemed "incomplete" and will be rejected. The applicant, if it so chooses, may withdraw the application, within the initial 90 days, if the application is "incomplete" and it is unable to provide the requested information. The withdrawn application would not be labeled as "rejected" or "denied." Once the withdrawn application is completed, the applicant may resubmit the application and applicable fees as a new application.

Please make all checks payable to the **South Carolina Department of Consumer Affairs.**

**PURSUANT TO THE PROVISIONS OF SOUTH CAROLINA CODE § 37-17-10 ET. SEQ. (2015) AS AMENDED, THE UNDERSIGNED HEREBY MAKES THE FOLLOWING STATEMENTS FOR THE PURPOSE OF REGISTERING TO CONDUCT BUSINESS AS A DISCOUNT MEDICAL PLAN ORGANIZATION (DMPO) IN THE STATE OF SOUTH CAROLINA:**

Name of DMPO: \_\_\_\_\_  
Date of Organization: \_\_\_\_\_ Federal ID#: \_\_\_\_\_  
Business Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Website: \_\_\_\_\_

Name of Primary Contact Person: \_\_\_\_\_  
Business Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_  
E-Mail Address: \_\_\_\_\_

Name of Secondary Contact Person: \_\_\_\_\_  
Business Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_  
E-Mail Address: \_\_\_\_\_

**PLEASE PROVIDE THIRTY (30) DAYS ADVANCE WRITTEN NOTICE OF ANY CHANGE IN ANY OF THE ABOVE INFORMATION TO THE DEPARTMENT.**

**ORGANIZATIONAL STRUCTURE**

- Corporation       Limited Liability Company  
 General Partnership       Limited Partnership       Sole Proprietorship  
 Other (specify) \_\_\_\_\_

1. Provide a current organizational chart of the applicant.
2. Provide a current copy of the Certificate of Authorization issued by the South Carolina Secretary of State demonstrating the applicant's authority to conduct business in South Carolina and that all state taxes and fees have been paid. Any business entity that fails to maintain its qualification with the South Carolina Secretary of State forfeits its right to do business in this state and must immediately surrender any registration certificates issued by this Department.
3. Provide the current contact information requested below for the applicant's current agent for service of process as registered with the South Carolina Secretary of State's office.

Name of Current  
South Carolina  
Agent for Service  
of Process:

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Business Address:

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City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

4. Attach a photocopy of your most recent license, registration certificate, or certification letter for each state in which the Applicant is currently authorized to provide DMPO services, or any subset, such as prescription drug discount cards. **Certifications should be attached in alphabetical order by state.**

**MANAGEMENT**

In the spaces provided below, provide the requested information for the individuals who are responsible for conducting the applicant DMPO's affairs, including, but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing committee, the officers, contracted management company personnel, and any person or entity owning or having the right to acquire ten percent or more of the voting securities of the applicant. Fill out each section completely. All persons who qualify as a member of applicant's management must be listed below.

**EACH NEW PROPOSED MEMBER OF MANAGEMENT NOT CURRENTLY REGISTERED IN SOUTH CAROLINA MUST EACH SUBMIT A *MANAGEMENT BIOGRAPHICAL AFFIDAVIT (FORM DMPO-03)*.**

Corporations: If the applicant is owned by another corporate entity, list any officers of the parent firm and the ultimate owners (natural persons) in the tables below that qualify management, and attach an organizational chart.

**Management Based on Ownership:**

List the names of all persons or entities who directly or indirectly own, control, hold with the power to vote, or hold proxies representing ten percent (10%) or more of the voting securities of the Applicant. Please note whether or not the person or entity is a new member of management since your last application. If necessary, attach additional sheet(s) providing the same information requested below.

Full Name And Address	Date of Birth (mm-dd-yyyy)	% Ownership	New?

**Compliance Note: The Family Independence Act of 1995 requires the South Carolina Department of Social Services – Child Enforcement Division (Division) to operate a license revocation program for the purpose of enforcing and establishing child support. In accordance with this Act, South Carolina law (§ 20-7-944) requires that all licensing entities submit to the Division licensee data for all new and renewal licenses issued. Therefore, identifying information (i.e., name, social security number and date of birth, etc.) for all members of management licensed with this renewal application will be forwarded to the Division upon the issuance of each renewal license. Personal information will not be used for any other purpose and is not subject to disclosure under the South Carolina Freedom of Information Act. South Carolina Code § 30-4-10 et seq.**



## **APPLICANT BUSINESS HISTORY**

**If any question is answered "Yes", attach separate page(s) detailing the circumstances (including any applicable details such as state, license number, dates, etc.)**

1. Since your last application, have any of the Applicant's existing or proposed management ever been convicted or found guilty of any misdemeanors or felonies (with the exception of minor traffic violations) in any jurisdiction or territory in the United States?

Yes       No

2. Since your last application, has either the Applicant or any of its existing or proposed management ever been refused a license, registration, or certification as a discount medical plan, or renewal thereof, in any jurisdiction or territory in the United States?

Yes       No

3. Since your last application, has either the Applicant or any of its existing or proposed management ever had a license revoked, suspended, or otherwise acted against (including probation, fine, or reprimand) in a disciplinary action in any jurisdiction or territory in the United States?

Yes       No

4. Since your last application, has either the Applicant or any of its existing or proposed management ever been involved in or owned an interest in an organization that has been adjudicated bankrupt, filed proceedings under the Bankruptcy Act, or has otherwise closed due to insolvency?

Yes       No

5. Since your last application, are any of the licenses, registrations, or certifications of the Applicant or any of its existing or proposed management currently under investigation or currently pending disciplinary action in any jurisdiction or territory in the United States?

Yes       No

6. Since your last application, has the Applicant or any of its existing or proposed management failed to satisfy any tax liabilities?

Yes       No

7. Since your last application, has the Applicant or any of its existing or proposed management had a lien or levy placed against it/them?

Yes       No

8. Since your last application, has the Applicant or any of its existing or proposed management been the subject of an indictment or a "cease and desist" order in any jurisdiction or territory in the United States?

Yes       No

9. Since your last application, has the Applicant or any of its existing or proposed management been the subject of a governmental investigation?

Yes       No

10. Is there any litigation or legal proceeding currently pending or threatened against the Applicant or any of its existing or proposed management in any jurisdiction or territory in the United States?

Yes       No

**SOUTH CAROLINA OPERATIONS**

Provide a list of all offices, including branch offices, located in South Carolina:

Check if the Applicant has no South Carolina offices.

Address	Contact Person	Telephone #	E-mail address

**DISCOUNT MEDICAL PLAN OPERATIONS AND MARKETING**

1. Attach a list all names (including trade names, brand names, private label names or DBAs) used to market the DMPO's discount program.

2. Does the DMPO or any of its marketers include any insurance coverage with the discount program?

Yes       No

3. If yes, please attach an explanation of the insurance benefits, including the name(s) of the insurer(s). Please submit copies of all policies.
4. Attach current copies of the form of any contract made or to be made between the applicant and any person for the performance on the applicant's behalf of any function, including, but not limited to, marketing, administration, enrollment, and subcontracting for the provision of health care services to customers. This should include internal marketing staff as well as external marketers, including call centers.
5. Do your agreements with external marketing companies permit those companies to further subcontract marketing functions to other companies (sub-marketers or private label brands) with or without your approval?  
 Yes     No
6. If yes, please attach an explanation of the DMPO's policies and procedures.
7. Provide an organizational chart showing all authorized marketer, sub-marketer, or private label companies and their relationship with the DMPO.
8. Provide copies of all current training materials for marketers and representatives (internal and external).
9. Attach a statement describing the proposed methods of marketing by the DMPO and its marketers/sub-marketers/private label brands.
10. Provide copies of all marketing materials that will be used in South Carolina and a description of the media (TV, Internet, mass mailing etc.) used for each of the materials submitted. This should include the marketing materials of the DMPO and any authorized marketer or sub-marketer of your plan, including private label brands. All advertisements must contain the name and address of the company offering the service and must conform to the name on file with the Department. In addition, these materials must clearly disclose the amount of all discounts offered. **IT IS IMPORTANT FOR YOU TO VERIFY THAT ALL MARKETING MATERIALS MEET THE REQUIREMENTS OF S.C. CODE SECTION 37-17-10 ET. SEQ. BEFORE SUBMITTING THEM WITH YOUR APPLICATION.**
11. Does the applicant require its external marketing companies, including private label brands, to get prior approval from the DMPO of their advertising materials?  
 Yes     No
12. If yes, attach a description of this procedure.
13. South Carolina law requires the prominent display of the Internet website address which contains an up-to-date list of the names and addresses of providers with which a DMPO has contracted directly or through a provider network on all advertising, marketing material, brochures and discount medical plan cards. What is that website address?  


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14. If any of the websites are password protected or for customers-only, please provide codes to the Department to enable a full review of the site(s).
15. Provide copies of all application forms used by the DMPO and its marketers/sub-marketers, including private label brands, to sign up customers. **IT IS IMPORTANT FOR YOU TO VERIFY THAT ALL FORMS MEET THE REQUIREMENTS OF S.C. CODE SECTION 37-17-10 ET. SEQ. BEFORE SUBMITTING THEM WITH YOUR APPLICATION.**
16. Provide copies of all the discount cards issued by the DMPO and its marketers/sub-marketers, including private label brands.



17. Attach a copy of the notice, included in membership agreements and marketing materials, that each customer receives stating the terms under which the discount medical plan may be returned or cancelled.
18. Attach a list of all additions and subtractions to your previously filed list of providers or provider networks with whom your DMPO has contracts or agreements to provide discounted health care services to South Carolina customers.
19. Attach copies of the form of all current contracts made or to be made between the applicant and any providers or provider networks regarding the provision of medical services to South Carolina customers.
20. Attach a detailed description of the customer complaint procedures to be established and maintained by the DMPO and its marketers/sub-marketers, including private label brands.

## **MARKETERS**

1. Provide a list of all of the Applicant's authorized marketers, as defined in S.C. Code Ann. § 37-17-20 (5), including any sub-marketers and private label brands. This information should be provided using either the **Marketer Company List (Form DMPO-04)** or in a report that you generate provided, however, that all of the information requested in the table below is included in the separate report.
2. How many representatives, as defined in S.C. Code Ann. § 37-17-20 (6), including those employed by all sub-marketers and private label brands, are authorized to market the Applicant's discount medical plans? \_\_\_\_\_
3. Provide a list of all of the Applicant's authorized representatives, including all representatives of authorized marketing companies, including sub-marketers and private label brands. This information should be provided using either the **Authorized Representative List (Form DMPO-05)** or in a report that you generate provided, however, that all of the information requested on that form is included in the separate report.

## **FINANCIAL**

1. Applicants must attach copies of the company's Audited Financial Statements for the most recent accounting period preceding this application. The most recent statement must be for annual period ending no earlier than 180 days before the date of this application, certified by two principal officers of the applicant (if the applicant is not a corporation, by others the administrator requires), and shall be attested to by an independent Certified Public Accountant. If the most recent audited financial statement currently available is dated more than 180 days before the date of this application, the applicant must certify to the Department that there have been no material adverse changes in the financial position of the company since the date of the last financial statements, and shall provide a copy of the next financial statement as soon as it becomes available.

If the applicant is a subsidiary of a parent entity that is publicly traded and that prepares audited financial statements reflecting the consolidated operations of the parent entity, the subsidiary may submit, in lieu of the certified financial statement of the applicant, the audited financial statement of the parent.

The financial statements must be prepared in accordance with generally accepted accounting principles and must include a statement of income and retained earnings, balance sheet, statement of changes in financial position (cash flow), and applicable footnotes. The financial statements also must reflect positive working capital and positive tangible net worth.

Information supplied regarding net worth is proprietary and confidential and is exempt from disclosure to third parties.

2. Applicants must provide a bond in the amount of \$50,000 as required by S.C. Code Ann. § 37-17-40(A)(3) (2015). A sample bond form is available as **(Form DMPO-06)**.

**AFFIDAVIT OF APPLICANT**

I swear or affirm and certify that I have completed and/or reviewed all information on this form and submitted with this Application, and to the best of my knowledge and belief, all information contained herein is true, correct and complete; and that there are no material omissions of fact which would have a bearing upon the South Carolina Department of Consumer Affairs' decision to grant the requested registration certificate. I further certify that I understand that giving false information constitutes cause for denial or revocation of the application and subjects me to criminal prosecution for perjury. I acknowledge that I have a duty and agree to update and correct this information as it changes.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Type or Print your Name and Title

SWORN TO AND SUBSCRIBED before me

this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

\_\_\_\_\_  
(SEAL)

Notary Public For \_\_\_\_\_

My Commission Expires:  
\_\_\_\_\_

**The completed Application should be submitted to:**

South Carolina Department of Consumer Affairs  
Attn: PEO Licensing and Regulation

**Mailing Address**  
P.O. Box 5757  
Columbia, SC 29250-5757

**Street Address**  
2221 Devine St. Suite 200  
Columbia, SC 29205

**Do not fax this form. An original, signed and notarized form is required.**

**The South Carolina Freedom of Information Act may require the S.C. Department of Consumer Affairs to release this form as a public record; however personal identifying information will be released only if required by law.**