COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT

Continuing Care Provider - Application Form

Pursuant to the Continuing Care Provider Registration and Disclosure Act
40 P.S. § 3201 et seq.

Type or Print - Complete All Information

PART I – IDENTIFICATION – PROVIDER

Employer Identification Number: -

Full Legal Name:

Address:	Street (Required) (If applicable, include P.O. Box)
	City State Zip Code

PART II – IDENTIFICATION – FACILITY

Employer Identification Number: ☐ same as provider or -

Full Name: (☐ fictitious name of provider)

Address:	Street (Required) (If applicable, include P.O. Box)
	City State Zip Code

Business Telephone: ( ) - Business Fax: ( ) - County:

PART III – APPLICANT'S CERTIFICATION

In accordance with the provisions and requirements of an Act of the General Assembly of the Commonwealth of Pennsylvania, entitled, "The Continuing Care Provider Registration and Disclosure Act," Act of June 18, 1984, P.L. 391, No. 82, effective December 18, 1984, application is hereby made for a certificate of authority to transact business in Pennsylvania as a continuing care provider for the facility identified above.

We agree to furnish your Department with a certified copy of the report of any examination made into the affairs of the provider and facility identified above and further agree to furnish you with proper authority to make any corrections to our annual statement that are brought to our attention.

The undersigned hereby certifies that the information contained in the attached Statement in Support of Application for a Certificate of Authority, and all appendices thereto, is true and correct to the best of the undersigned's knowledge, information, and belief.

Notary Seal

(Please print or type name of Provider)

Subscribed and sworn before me on this

(Signature of Provider or Authorized Representative)

_____day of _____, 20____.

Commission Expires:

(Title of Authorized Representative)