State of New Hampshire
Insurance Department

Application for Permanent Certificate of Authority
As a Continuing Care Facility

Application is hereby made on behalf of the continuing care facility herein named for a license authorizing it to transact business and otherwise perform as a continuing care facility in New Hampshire.

1. The exact name of the continuing care facility is:

    _____

    (If the name is not in English, state it and give the exact literal translation.)

2. The type of business organization of the continuing care facility is:

    _____

    (corporation, partnership, or other)

3. Organized under the laws of the State of_____

4. Its home or U.S. Branch office is at_____
    (give number, street, city or town, and state)

5. Its principal mailing address is:

    _____

    _____

6. Has the Department issued a Temporary Certificate of Authority to the Applicant? Check Yes or No.

    Yes_____   No_____

    If yes, is checked, what is the expiration date of the Temporary Certificate of Authority?

7. By signing this application on behalf of the continuing care facility, the person responsible for making this application certifies that:

    (a) The applicant agrees to abide by the rules and regulations of the Department.

(b) The license or authority of the facility or any affiliated facility of the controlling organization, if any, in any state, district or country has at no time been revoked, suspended or canceled, nor has any previous application for a license or authority been denied by any state, district or country, except as stated below. (Give full details regarding any revocation, suspension, cancellation or denial of application. Attach separate pages if necessary.

(c) All requirements of RSA 420-D imposed upon the applicant have been met, and

(d) All statements made in this application or in any of the supporting documents attached are, to the best of my knowledge and belief, true and complete.

Signed on behalf of the applicant by: _____

Name (Typed): _____

Title: _____

Date: _____