



# STATE OF SOUTH CAROLINA DEPARTMENT OF CONSUMER AFFAIRS

## DISCOUNT MEDICAL PLAN ORGANIZATIONS

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

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

**Street Address**  
293 Greystone Blvd., Ste. 400  
Columbia, SC 29210-8004

## MARKETER COMPANY LIST

(Please type or print in black ink)

If filling in the form electronically, copy and paste the table as many times as needed onto subsequent pages. If filling in by hand, make as many copies of the second page as needed. This information may also be provided in a report that you generate, provided that all of the information requested in the table below is included. **Include all marketer companies, including sub-marketers and private label brands.**

<b>Name of DMPO</b>		<b>Date</b>	
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<b>Marketer Company</b>		<b>FEIN</b>	
<b>Contact Person</b>			
<b>Mailing Address</b>			
<b>City</b>	<b>State</b>		<b>Zip</b>
<b>Telephone Number</b>	<b>Fax Number</b>		
<b>Number of Representatives</b>	<b>Date Relationship Initiated</b>		
<b>Company Website</b>		<b>Customer Info Website</b>	

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**AFFIDAVIT OF APPLICANT**

I swear or affirm and certify that I have completed and/or reviewed all information on this form, 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:

\_\_\_\_\_