



STATE OF SOUTH CAROLINA DEPARTMENT OF CONSUMER AFFAIRS



Mailing Address
P.O. Box 5757
Columbia, SC 29250-5246

DISCOUNT MEDICAL PLAN ORGANIZATIONS

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

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

Discount Medical Plan Organization Authorized Representative List

(Please type or print in black ink)

Please provide the information requested below for ALL representatives authorized to market your discount medical plans. If additional space is needed, use additional copies of page 3, or provide the same information requested below in a self-generated report **The South Carolina Freedom of Information Act may require the Department of Consumer Affairs to release this form as a public record; however personal identifying information will be released only if required by law.**

#	Representative Name	Social Security Number*	Marketer Company and Address
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*** Compliance Note: The Family Independence Act of 1995 required 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, etc.) for all individuals licensed or registered with this application will be forwarded to the Division upon the issuance of each 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.**

#	Representative Name	Social Security Number*	Marketer Company and Address
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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:
