



Department of Consumer and Business Services

Insurance Division – 4

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**Discount Medical Plan
Organization Renewal**

1. Name of applicant: _____
2. Federal identification number or IRS taxpayer identification number: _____
3. Oregon license number: _____
4. Mailing address: _____
City: _____ State: _____ ZIP: _____
5. Street address (if different): _____
City: _____ State: _____ ZIP: _____
Phone: ____ - ____ - ____ Fax: ____ - ____ - ____ E-mail: _____
6. Contact person: _____
Phone: ____ - ____ - ____ Fax: ____ - ____ - ____ E-mail: _____
7. Were there any other changes? (Example: Web site, domicile state) Please list: _____

8. During the past year has there been any changes to your registration or license in another state or jurisdiction? Yes No
If yes, please describe: _____

I, _____ certify that I am an officer of the organization named in the foregoing application, that I know the contents thereof, and each of the statements and answers made is true and complete to the best of my knowledge and belief. Further, the organization submits to the jurisdiction of any court of competent jurisdiction in Oregon for the adjudication of any issues arising out of its discount medical plans, agrees to comply with all requirements necessary to give such court jurisdiction, and will abide by the final decision of such court or any appellate court in the event of an appeal.

Date

Signature

Note: A new license is not issued when renewed. We do not normally send confirmation of renewal. If you want confirmation of your renewal please send a stamped, self-addressed envelope with your renewal.