



***INDIANA DEPARTMENT OF INSURANCE***

**ANNUAL REPORT**

**OF THE**

\_\_\_\_\_  
**(Name of the Discount Medical Program Organization)**

\_\_\_\_\_  
**(DMPO License #)**

**LOCATED IN**

\_\_\_\_\_  
**(CITY AND STATE)**

**FOR FISCAL YEAR ENDING** \_\_\_\_\_

**Contact Name** \_\_\_\_\_

**Phone** \_\_\_\_\_

**Email** \_\_\_\_\_

*As required by IC 27-17-7  
of the Indiana Insurance Code*

*To be filed with the IDOI  
not later than 3 months  
following the end of the DMPO fiscal year*

**Answer the questions below as they pertain to the fiscal year covered by this report. Attach any additional information or documentation required as a result of the responses.**

- A. Have there been any changes to the DMPOs basic documents, such as by-laws or articles of incorporation? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, attach an explanation of all such changes and copies of the corresponding documents.
- B. Have there been any changes in the DMPOs ownership? If yes, attach a statement containing complete details and an organizational chart depicting all direct and indirect relationships between the DMPO and all of its affiliates, including the ultimate parent corporation of all such entities. \_\_\_\_\_ Yes \_\_\_\_\_ No
- C. Was the DMPO a party to any civil or criminal legal action, other than as a plaintiff in a civil matter in the previous fiscal year? If yes, attach a statement containing the complete details. \_\_\_\_\_ Yes \_\_\_\_\_ No
- D. Was the DMPOs certificate of authority, license or registration to do business suspended or revoked by any governmental agency, or did any governmental agency initiate formal legal proceedings for said purpose in the previous fiscal year? If yes, attach a statement containing the complete details. \_\_\_\_\_ Yes \_\_\_\_\_ No
- E. Was the DMPO or any of its owners, officers, or directors convicted of or enter a plea of *nolo contendere* to a felony in any state without regard to whether adjudication was withheld? If yes, attach a statement containing the complete details. \_\_\_\_\_ Yes \_\_\_\_\_ No
- F. Indicate the number of Indiana residents who are current card-holders in your DMPO. \_\_\_\_\_
- G. Submit list of program providers in Indiana to include name, address, and phone number.

*Failure to file the annual report will result in a fine of \$500 per day for the first ten (10) days of noncompliance and \$1,000 per day for the eleventh day and each subsequent day thereafter.*