State of California
Health and Human Services Agency
Department of Managed Health Care
ELECTRONIC FILING SIGNATURE VERIFICATION
DMHC 10-0066 Rev: 01/14

DEPARTMENT OF Managed Health Care

ELECTRONIC FILING SIGNATURE VERIFICATION

Original hardcopy **MUST** be returned to**:** **Department of Managed Health Care**
ATTN: Licensing Administration
980 9th Street, Suite 500
Sacramento, CA 95814

1.0 IDENTIFICATION OF PARTIES

This agreement is between the State of California, Department of Managed Health Care (DMHC) and California Health Care Service Plans, hereinafter referred to as "HCSP".

Health Care Service Plan (HCSP) INFORMATION

HCSP Name (legal)	HCSP License Number **933-**
DBA (if applicable)	

Address (number, street)	City	State	ZIP Code

SIGNATORY INFORMATION

Name (First, Last)	Phone Number
Title	E-mail

REQUESTED ACTION:

☐ Signatory Contact
(for Electronic Execution of eFile)

SIGNATURE

Signature of Individual (original required; ***use blue ink***) _____ Date _____

The undersigned, being fully authorized to execute on behalf of the above identified health care service plan, hereby certifies under penalty of perjury pursuant to the laws of the State of California as to this Electronic Filing Signature Verification and any other electronically submitted application, amendment, material modification, or other required filing and each exhibit and attachment thereto, that the undersigned knows the contents thereof and that the statements therein are true and correct. The undersigned agrees that all future documents filed electronically with the Department of Managed Health Care pursuant to this verification which include the typed name of the undersigned will have the same force and effect as if the undersigned had signed the document by hand and subject to this certification under penalty of perjury.

Authorized by (must be Signatory on file with DMHC for this Plan) _____ Date _____
SIGNATURE

_____
PRINT NAME