

**ELECTRONIC FILING SIGNATURE VERIFICATION**

Original hardcopy **MUST** be returned to: **Department of Managed Health Care  
ATTN: Licensing Administration  
980 9<sup>th</sup> 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	
DBA (if applicable)		<b>933-</b>	
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