Applicant Name (Company) Puget Sound Health Partners

NAIC: 12906
FEIN: 42-1720801

RECEIVED
2 1 2009
INSURANCE COMMISSIONER
COMPANY SUPERVISION

BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority.

(Print or Type)

Full Name, Address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Puget Sound Health Partners
7502 Lakewood Drive West, Suite A
Lakewood, WA 98499

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. Affiant's Full Name (Initials Not Acceptable). April Denise Golenor
2. a. Are you a citizen of the United States? No
   b. Are you a citizen of any other country, if so, what country? No
3. Affiant's Occupation or Profession. Chief Executive Officer
4. Affiant's business address. 7502 Lakewood Dr. W Ste A Lakewood, WA 98499
   Business telephone. 253-284-3931
5. Education and Training:

College/ University	City/State	Dates Attended (MM/YY)	Degree Obtained
California State University	San Bernadino, CA	1994	Bachelor of Science
Graduate Studies: College/University			
Other Training:			Degree/Certification Obtained
Villanova University	Villanova, PA	10/08 - 01/09	Lean Six Sigma Certificate

(Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number in the space provided in the Biographical Affidavit Supplemental Information.)

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INSURANCE COMMISSIONER
COMPANY SUPERVISION

Applicant Name (Company) Puget Sound Health Partners NAIC: 12909
FEIN: 42-1720801

6. List of memberships in professional societies and associations.

Name of Society/Association	Contact Name	Address of Society/Association	Telephone Number of Society/Association

7. Present or proposed position with the applicant entity. Chief Executive Officer

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years.

Beginning/Ending Dates (MM/YY) 02/09 - Present Employer's Name Puget Sound Health Partners
Address 7502 Lakewood Dr W, Ste A City Lakewood State/Province WA
Country USA Postal Code 98499 Phone 253-284-3931 Offices/Positions Held CEO
Supervisor / Contact Mariella Cummings

Beginning/Ending Dates (MM/YY) 03/03 - 04/08 Employer's Name Group Health Options, Inc.
Address 521 Wall Street City Seattle State/Province WA
Country USA Postal Code 98121 Phone 206-448-2920 Offices/Positions Held COO & VP, President, & CEO
Supervisor / Contact Maureen McLaughlin

Beginning/Ending Dates (MM/YY) 06/96 - 11/02 Employer's Name PacifiCare Health Systems
Address 5701 Katella Ave City Cyress State/Province WA
Country USA Postal Code 90630 Phone 800-624-8822 Offices/Positions Held CFO & VP Health Plan Admin
Supervisor / Contact Susan Berkel

Beginning/Ending Dates (MM/YY) 06-94 - 06/96 Employer's Name Ernst & Young LLP
Address 18111 Von Karman City Irvine State/Province CA
Country USA Postal Code 92612 Phone 949-794-2300 Offices/Positions Held Sr. Auditor
Supervisor / Contact Cheryl Moreno

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Applicant Name (Company) Puget Sound Health Partners NAIC: 12909
FEIN: 42-1720801

9. a. Have you ever been in a position which required a fidelity bond? No If any claims were made on the bond, give details. _____

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked? If yes, give details. No

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license (s) issued.. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, "SSN", "12-SSN-345" or "1234-SSN" (last 6 digits)). Attach additional pages if the space provided is insufficient

None

Organization/Issuer of License _____ Address _____

City _____ State/Province _____ Country _____ Postal Code _____

License Type _____ License # _____ Date Issued (MM/YY) _____

Date Expired (MM/YY) _____ Reason for Termination _____

Non-insurance Regulatory Phone Number (if known _____

Organization /Issuer of License _____ Address _____

City _____ State/Province _____ Country _____ Postal Code _____

License Type _____ License # _____ Date Issued (MM/YY) _____

Date Expired (MM/YY) _____ Reason for Termination _____

Non-insurance Regulatory Phone Number (if known) _____

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:

a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency? No

b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action? No

c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action? No

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses? No

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e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses? No

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses? No

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking? No

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute? No

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government? No

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity? No

If the response to any question above is answered "Yes", please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.

None

If any of the stock is pledged or hypothecated in any way, give details.

13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified. If the answer is "Yes", please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

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Applicant Name (Company) Puget Sound Health Partners NAIC: 12909
FEIN: 42-1720801

If any of the shares of stock are pledged or hypothecated in any way, give details.

14. Have you ever been adjudged a bankrupt? No

If yes, provide details.

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity? If yes, please indicate and give details. When responding to questions (b) and (c) affiant should also include any events within twelve (12) months after his or her departure from the entity. No

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or Governmental-licensing agency? No

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)? No

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action? No

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 31 day of March 2009 at Seattle, WA
I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

[redacted]
(Signature of Affiant)

State of WASHINGTON County of King

The foregoing instrument was acknowledged before me this 31st day of March 20 09 By April Golenor, and:

who is personally known to me, or

who produced the following identification: WDL Lic[redacted]

SEAL
DONNA M. PAINCHAUD
NOTARY PUBLIC
STATE OF WASHINGTON
COMMISSION EXPIRES 08-01-11

Notary Public
Donna M. Painchaud
Printed Notary Name
08-01-2011
My Commission Expires

Applicant Name (Company) Puget Sound Health Partners NAIC: 12909
FEIN: 42-1720801

BIOGRAPHICAL AFFIDAVIT
Supplemental Personal Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority.

Full Name, Address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Puget Sound Health Partners
7502 Lakewood Drive West, Suite A
Lakewood, WA 98499

1. Affiant's Full Name (Initials Not Acceptable). April Denise Golenor
2. Have you ever used any other name including nickname, maiden name or aliases? Yes

If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

Beginning/Ending Dates(S) Used (MM/YY)	Name(s)	Reason (If None, indicate such)
04/68/05/87	April Denise Harlow	Maiden Name
05/87/12/90	April Denise Keller	Married Name
12/90/07/95	April Denise Harlow	Maiden Name
07/95 Present	April Denise Golenor	Married Name
/		
/		
/		
/		
/		

Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another.

3. Affiant's Social Security Number [redacted]
4. Government Identification Number if not a U.S. Citizen
5. Foreign Student ID# (if applicable)
6. Date of Birth: (MM/DD/YY) [redacted] Place of Birth: City [redacted]
State/Province CA Country USA

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Applicant Name (Company) Puget Sound Health Partners NAIC: 12909
FEIN: 42-1720801

7. Name of Affiant's Spouse (if applicable) [redacted]

8. List your residences for the last ten (10) years starting with your current address, giving:

Beginning/Ending Dates (MM/YY)	Address	City	State/Province	Country	Postal Code
05/03-Present	[redacted]	[redacted]	WA	USA	[redacted]
11/03 - 05/03	[redacted]	[redacted]	WA	USA	[redacted]
06/02 - 10/03	[redacted]	[redacted]	GU	USA	[redacted]
12/99 - 05/02	[redacted]	[redacted]	WA	USA	[redacted]

Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another.

Dated and signed this 31 day of March, 2009, at Lakewood, WA
I certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

[redacted]
(Signature of Affiant)

State of WASHINGTON County of PIERCE

The foregoing instrument was acknowledged before me this 31st day of MARCH, 2009
by APRIL GOLENOR, and:

who is personally known to me, or

who produced the following identification: _____

[SEAL]

Vicki L Knox
Notary Public
VICKI L KNOX
Printed Notary Name
7-26-10
My Commission Expires

Applicant Name (Company) Puget Sound Health Partners

NAIC: 12809
FEIN: 42-1720801

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS (*All states except California, Minnesota and Oklahoma*)

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of _____ _____ ***[Insert* company name]**("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both)("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency ("CRA") that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact _____ _____ ***[Insert* company's designated person, position, or department, address and phone]**.

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act."

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) twelve (12) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

[redacted]

[redacted] (Printed Full Na[redacted]

[redacted] 3-31-09

(Signature) (Date)

State of WASHINGTON County of PIERCE

The foregoing instrument was acknowledged before me this 31ST day of MARCH, 20 09 By APRIL GOLENOR, and

who is personally known to me, or

who produced the following identification: _____

[SEAL]

Vicki L Knox
Notary Public

VICKI L. KNOX
Printed Notary Name

07-26-2010
My Commission Expires

VICKI L. KNOX
COMMISSION EXPIRES
NOTARY
PUBLIC
07-26-10
STATE OF WASHINGTON

O/C

Rodica Murphy

500 CAPITOL BLVD
TUMWATER WA

Applicant Name Gary Ray Goin

NAIC No. _____
FEIN: _____

BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority.

(Print or Type)

Full Name, Address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Puget Sound Health Partners
708 Broadway Suit 400
Tacoma, WA 98402 (253) 779-8830

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. a. Affiant's Full Name (Initials Not Acceptable). Gary Ray Goin MD NAIC - DO MATCH

   b. Maiden Name (if applicable). _____

2. a. Have you ever had your name changed? NO If yes, give the reason for the change and provide the full name(s).

   b. Other names used at any time (including aliases).
   No other names

3. a. Are you a citizen of the United States? Yes

   b. Are you a citizen of any other country, if so, what country? NO

4. Affiant's Occupation or Profession. Family Physician

5. Affiant's business address. 412-D Black Hills Ln SW
   Business telephone. (360) 754-6460 Olympia, WA 98502

Applicant Name Gary Ray Goin MD

NAIC No. _____
FEIN: _____

6. Education and Training:

College/ University	City/ State	Dates Attended (MM/YY)	Degree Obtained
Eastern WA. Univ.	Cheney, WA.	09/74-06/76	
Willamette Univ.	Salem, OR	08/76-05/78	BA

Graduate Studies: College/ University	City/ State	Dates Attended (MM/YY)	Degree Obtained
Oregon Health Sciences Univ.	Portland, OR.	09/78-06/82	Medical Doctor

Other Training: Name	City/ State	Dates Attended (MM/YY)	Degree/Certification Obtained
Kern Medical Center	Bakersfield, CA.	6/82-6/85	3 year Residency in Family Practice

(Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number in the space provided in the Biographical Affidavit Supplemental Information.)

7. List of memberships in professional societies and associations.

Name of Society/Association	Contact Name	Address of Society/Association	Telephone Number of Society/Association
American Academy of Family Practice		11400 Tomahawk Creek Parkway Leawood, KS 66211-2672 or P.O. Box 11210 Shawnee Mission, KS 66207-1210	1 800-274-2237

8. Present or proposed position with the applicant entity. Member of Board of Directors

9. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years.

Beginning/Ending Dates (MM/YY) 09/85 - 10/06 Employers' Name Self-employed physician

Address 412-D Black Hills Ln SW City Olympia State/Province WA

Country Thurston Postal Code _____ Phone 360 754-6460 Offices/Positions Held Physician

Supervisor / Contact _____

Beginning/Ending Dates (MM/YY) _____ - _____ Employers' Name _____

Address _____ City _____ State/Province _____

Country _____ Postal Code _____ Phone _____ Offices/Positions Held _____

Supervisor / Contact _____

Applicant Name Gary Ray Goin MD

NAIC No. _____
FEIN: _____

Beginning/Ending Dates (MM/YY) _____ - _____ Employers' Name _____

Address _____ City _____ State/Province _____

Country _____ Postal Code _____ Phone _____ Offices/Positions Held _____

Supervisor / Contact _____

Beginning/Ending Dates (MM/YY) _____ - _____ Employers' Name _____

Address _____ City _____ State/Province _____

Country _____ Postal Code _____ Phone _____ Offices/Positions Held _____

Supervisor / Contact _____

10. a. Have you ever been in a position which required a fidelity bond? NO If any claims were made on the bond, give details. _____

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked? If yes, give details. NO

11. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license (s) issued. Attach additional pages if the space provided is insufficient.

Organization/Issuer of License State of Washington ~~Health~~ Professions Quality Assurance Div Address 101 Israel Rd S.E.

City Tumwater State/Province WA Country USA Postal Code _____

License Type M. D. License # MD00022694 Date Issued (MM/YY) 03/85 → 6-8-2008

Date Expired (MM/YY) 06/08 Reason for Termination active license

Non-insurance Regulatory Phone Number (if known _____

Organization /Issuer of License US Drug Enforcement ~~Agency~~ Administration Address _____

City Washington DC State/Province DC Country USA Postal Code _____

License Type Controlled Substance Prescribing License # AG2400721 Date Issued (MM/YY) 09/05

Date Expired (MM/YY) 09/08 Reason for Termination active

Non-insurance Regulatory Phone Number (if known) _____

Applicant Name Gary Ray Goin MD

NAIC No.
FEIN:

12. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:

a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency? No

b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action? No

c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action? NO

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses? NO

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses? NO

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses? NO

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking? NO

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute? NO

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government? NO

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity? NO

Deleted: ,

If the response to any question above is answered "Yes", please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

13. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. None

Applicant Name Gary Ray Goin MD

NAIC No. _____
FEIN: _____

If any of the stock is pledged or hypothecated in any way, give details. _____

14. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified. If the answer is "Yes", please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

NO

If any of the shares of stock are pledged or hypothecated in any way, give details.

15. Have you ever been adjudged a bankrupt? NO If yes, provide details

16. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity? If yes, please indicate and give details. When responding to questions (b) and (c) affiant should also include any events within twelve (12) months after his or her departure from the entity.

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or Governmental-licensing agency? NO

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)? NO

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action? NO

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this _____ day of _____ 20__ at _____ I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

[redacted]
(Signature of Affiant)

Oct 27, 2006
Date

State of Washington County of Thurston

The foregoing instrument was acknowledged before me this 27th day of October, 20 06 By Gary Goin, MD, and:

☐ who is personally known to me, or

☒ who produced the following identification: WA DL

S. Lazette Wiley
Notary Public

S. Lazette Wiley
Printed Notary Name

01/19/2010
My Commission Expires

S. LAZETTE WILEY NOTARY PUBLIC STATE OF WASHINGTON MY COMMISSION EXPIRES 1-19-10

S. LAFETTE
NOTARY
PUBLIC
STATE OF

Applicant Name Gary Ray Goin MD

NAIC No. _____
FEIN: _____

BIOGRAPHICAL AFFIDAVIT
Supplemental Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority.

Full Name, Address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Puget Sound Health Partners
708 Broadway Suite 400
Tacoma, WA. 98402 (253) 779-8830

1. a. Affiant's Full Name (Initials Not Acceptable). Gary R. Goin MD

   b. Maiden Name (if applicable) [redacted]

2. Affiant's Social Security Number [redacted]

3. Government Identification Number if not a U.S. Citizen _____

4. Foreign Student ID# (if applicable) _____

5. Date of Birth: (MM/DD/YY) [redacted] lace of Birth: City [redacted]
   State/Province Oregon Country USA.

6. Name of Affiant's Spouse (if applicable) [redacted]

7. List your residences for the last ten (10) years starting with your current address, giving:

Beginning/Ending Dates (MM/YY)	Address	City	State/ Province	Country	Postal Code
09/1994/present	[redacted]				

Applicant Name Gary Ray Goin MD

NAIC No. _____

FEIN: _____

Dated and signed this 27th day of October, 20 06 at Olympia, WA I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

[redacted]

(Signature of Affiant)

Oct 27, 2006

Date

State of Washington County of Thurston

The foregoing instrument was acknowledged before me this 27th day of October, 20 06 By Gary Goin, MD, and:

☐ who is personally known to me, or

☒ who produced the following identification: WA DL

S. Lozette Wiley

Notary Public

S. Lozette Wiley

Printed Notary Name

01/19/2010

My Commission Expires

[SEAL]

LAFAYETTE
STATE OF
NOTARY
PUBLIC

Applicant Name Gary Ray Goin MD

NAIC No. _____
FEIN: _____

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS*(All states except California, Minnesota and Oklahoma)*

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of _____ **[*insert* company name]**("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both)("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency ("CRA") that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact _____**[*insert* company's designated person, position, or department, address and phone]**.

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act."

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) twelve (12) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

Gary Ray Goin MD [redacted]
(Printed Full Name and Residence Address)

[redacted] Oct 27, 2006
(Signature) (Date)

State of WA County of Thurston

The foregoing instrument was acknowledged before me this 27th day of October 20 06 By Gary Goin, MD and

☐ who is personally known to me, or

☒ who produced the following identification: WA DL

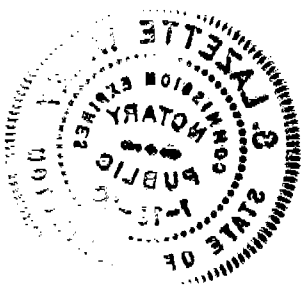
S. Lazette Wiley
Notary Public

S. Lazette Wiley
Printed Notary Name

01/19/2010
My Commission Expires

[SEAL]

LAZETTE WILEY NOTARY PUBLIC 1-19-10 STATE OF WASHINGTON


STATE OF
NOTARY
PUBLIC
COMMISSION EXPIRES
G. LAFETTE

Applicant Name Gary Ray Goin

NAIC No. _____
FEIN: _____

BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority.

(Print or Type)

Full Name, Address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Puget Sound Health Partners
708 Broadway Suit 400
Tacoma, WA 98402 (253) 779-8830

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. a. Affiant's Full Name (Initials Not Acceptable). Gary Ray Goin MD

   b. Maiden Name (if applicable). _____

2. a. Have you ever had your name changed? NO If yes, give the reason for the change and provide the full name(s).

   b. Other names used at any time (including aliases).
   No other names

3. a. Are you a citizen of the United States? Yes

   b. Are you a citizen of any other country, if so, what country? NO

4. Affiant's Occupation or Profession. Family Physician

5. Affiant's business address. 412-D Black Hills Ln SW
   Business telephone. (360) 754-6460 Olympia, WA 98502

Applicant Name Gary Ray Goin MD

NAIC No. _____
FEIN: _____

6. *Education and Training:*

College/ University	City/ State	Dates Attended (MM/YY)	Degree Obtained
Eastern WA. Univ.	Cheney, WA.	09/74-06/76	
Willamette Univ.	Salem, OR	08/76-05/78	BA

Graduate Studies: College/ University	City/ State	Dates Attended (MM/YY)	Degree Obtained
Oregon Health Sciences Univ.	Portland, OR.	09/78-06/82	Medical Doctor

Other Training: Name	City/ State	Dates Attended (MM/YY)	Degree/Certification Obtained
Kern Medical Center	Bakersfield, CA.	6/82-6/85	3 year Residency in Family Practice

(Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number in the space provided in the Biographical Affidavit Supplemental Information.)

7. List of memberships in professional societies and associations.

Name of Society/Association	Contact Name	Address of Society/Association	Telephone Number of Society/Association
American Academy of Family Practice		11400 Tomahawk Creek Parkway Leawood, KS 66211-2672 or P.O. Box 11210 Shawnee Mission, KS 66207-1210	1 800-274-2237

8. Present or proposed position with the applicant entity. Member of Board of Directors

9. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years.

Beginning/Ending Dates (MM/YY) 09/85 - 10/06 Employers' Name Self-employed physician

Address 412-D Black Hills Ln SW City Olympia State/Province WA

Country Thurston Postal Code _____ Phone 360 754-6460 Offices/Positions Held Physician

Supervisor / Contact _____

Beginning/Ending Dates (MM/YY) _____ - _____ Employers' Name _____

Address _____ City _____ State/Province _____

Country _____ Postal Code _____ Phone _____ Offices/Positions Held _____

Supervisor / Contact _____

Applicant Name Gary Kay Goinmy

NAIC No. _____
FEIN: _____

Beginning/Ending Dates (MM/YY) _____ - _____ Employers' Name _____

Address _____ City _____ State/Province _____

Country _____ Postal Code _____ Phone _____ Offices/Positions Held _____

Supervisor / Contact _____

Beginning/Ending Dates (MM/YY) _____ - _____ Employers' Name _____

Address _____ City _____ State/Province _____

Country _____ Postal Code _____ Phone _____ Offices/Positions Held _____

Supervisor / Contact _____

10. a. Have you ever been in a position which required a fidelity bond? NO If any claims were made on the bond, give details. _____

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked? If yes, give details. NO

11. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license (s) issued. Attach additional pages if the space provided is insufficient.

Organization/Issuer of License State of Washington ~~Health~~ Health Professions Quality Assurance Div Address 101 Israel Rd S.E.

City Tumwater State/Province WA Country USA Postal Code _____

License Type M. D. License # M [redacted] Date Issued (MM/YY) 03/85 → 6-8-2008

Date Expired (MM/YY) 06/08 Reason for Termination active license

Non-insurance Regulatory Phone Number (if known _____

Organization /Issuer of License US Drug Enforcement ~~Agency~~ Administration Address _____

City Washington DC State/Province DC Country USA Postal Code _____

License Type Controlled Substance Prescribing License # [redacted] Date Issued (MM/YY) 09/05

Date Expired (MM/YY) 09/08 Reason for Termination active

Non-insurance Regulatory Phone Number (if known) _____

Applicant Name Gary Ray Goin MD

NAIC No. _____
FEIN: _____

12. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:

a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency? No

b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action? No

c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action? NO

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses? NO

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses? NO

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses? NO

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking? NO

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute? NO

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government? NO

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity? NO

Deleted: ,

If the response to any question above is answered "Yes", please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

13. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. None

Applicant Name Gary Ray Goin MD

NAIC No. _____
FEIN: _____

If any of the stock is pledged or hypothecated in any way, give details. _____

14. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified. If the answer is "Yes", please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

NO

If any of the shares of stock are pledged or hypothecated in any way, give details.

15. Have you ever been adjudged a bankrupt? NO If yes, provide details

16. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity? If yes, please indicate and give details. When responding to questions (b) and (c) affiant should also include any events within twelve (12) months after his or her departure from the entity.

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or Governmental-licensing agency? NO

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)? NO

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action? NO

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this _____ day of _____ 20__ at _____ I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

[redacted]
(Signature of Affiant)

Oct 27, 2006
Date

State of Washington County of Thurston

The foregoing instrument was acknowledged before me this 27th day of October, 20 06 By Gary Goin, MD, and:

☐ who is personally known to me, or

☒ who produced the following identification: WA DL

S. Lazette Wiley
Notary Public

S. Lazette Wiley
Printed Notary Name

01/19/2010
My Commission Expires

S. LAZETTE WILEY NOTARY PUBLIC STATE OF WASHINGTON COMMISSION EXPIRES 1-19-10

Applicant Name Gary Ray Goin MD

NAIC No. _____
FEIN: _____

BIOGRAPHICAL AFFIDAVIT
Supplemental Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority.

Full Name, Address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Puget Sound Health Partners
708 Broadway Suite 400
Tacoma, WA. 98402 (253) 779-8830

1. a. Affiant's Full Name (Initials Not Acceptable). Gary R. Goin MD

   b. Maiden Name (if applicable) _____

2. Affiant's Social Security Number [redacted]

3. Government Identification Number if not a U.S. Citizen _____

4. Foreign Student ID# (if applicable) _____

5. Date of Birth: (MM/DD/YY) [redacted] Place of Birth: City [redacted]
   State/Province Oregon Country USA.

6. Name of Affiant's Spouse (if applicable) [redacted]

7. List your residences for the last ten (10) years starting with your current address, giving:

Beginning/Ending Dates (MM/YY)	Address	City	State/ Province	Country	Postal Code
09/1994/Present	[redacted]				

Applicant Name Gary Ray Goin MD

NAIC No. _____

FEIN: _____

Dated and signed this 27th day of October, 20 06 at Olympia, WA I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

[redacted]

(Signature of Affiant)

Oct 27, 2006

Date

State of Washington County of Thurston

The foregoing instrument was acknowledged before me this 27th day of October, 20 06 By Gary Goin, MD, and:

☐ who is personally known to me, or

☒ who produced the following identification: WA DL

S. Lazette Wiley

Notary Public

S. Lazette Wiley

Printed Notary Name

01/19/2010

My Commission Expires

[SEAL]

S. LAZETTE WILEY
COMMISSION EXPIRES
NOTARY
PUBLIC
1-19-10
STATE OF

Applicant Name Gary Ray Goin MD

NAIC No. _____
FEIN: _____

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS(*All states except California, Minnesota and Oklahoma*)

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of _____[***insert* company name**]("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both)("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency ("CRA") that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact _____[***insert* company's designated person, position, or department, address and phone**].

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act."

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) twelve (12) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

Gary Ray Goin MD [redacted]
(Printed Full Name and Residence Address)

[redacted]
(Signature)

Oct 27, 2006
(Date)

State of WA County of Thurston

The foregoing instrument was acknowledged before me this 27th day of October 20 06 By Gary Goin, MD and

☐ who is personally known to me, or

☒ who produced the following identification: WA DL

[SEAL]

S. Lazette Wiley
Notary Public

S. Lazette Wiley
Printed Notary Name

01/19/2010
My Commission Expires

S. LAZETTE WILEY NOTARY PUBLIC STATE OF WASHINGTON 1-19-10

Applicant Name John S. Van Bodegom

NAIC No. _____
FEIN: _____

BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority.

(Print or Type)

Full Name, Address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Proposed Entity Puget Sound Health Partners, Inc.
~~Address and telephone number not yet established~~
708 Broadway, Suite 400, Tacoma, WA 98402 253-779-8830

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. a. Affiant's Full Name (Initials Not Acceptable). John Schuyler Van Bodegom

   b. Maiden Name (if applicable). NAIC - No MATCH

2. a. Have you ever had your name changed? No If yes, give the reason for the change and provide the full name(s).

   b. Other names used at any time (including aliases).
   None

3. a. Are you a citizen of the United States? Yes

   b. Are you a citizen of any other country, if so, what country? No

4. Affiant's Occupation or Profession. Physician

5. Affiant's business address. Seahurst Clinic, 16110 S.W. 8th St, Bldg A-2, Burien WA 98166

   Business telephone. 206-242-8280

Applicant Name John S. Van Bodegom

NAIC No. _____
FEIN: _____

6. Education and Training:

College/ University	City/ State	Dates Attended (MM/YY)	Degree Obtained
Saint Olaf's College	Northfield, Minn.	09/63 – 06/64	None
University of Oregon	Eugene, Oregon	09/64 – 06/67	Bachelors Degree

Graduate Studies: College/ University	City/ State	Dates Attended (MM/YY)	Degree Obtained
Tulane School of Medicine	New Orleans, LA	09/67 – 06/71	M.D.

Other Training: Name	City/ State	Dates Attended (MM/YY)	Degree/Certification Obtained
Internship, Harborview Medical Center	Seattle, WA	6/71 – 06/72	
Residency in Internal Medicine, Univ. of WA	Seattle, WA	06/74 – 06/77	Board Certification in Internal Medicine

(Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number in the space provided in the Biographical Affidavit Supplemental Information.)

7. List of memberships in professional societies and associations.

Name of Society/Association	Contact Name	Address of Society/Association	Telephone Number of Society/Association
King County Medical Society			

8. Present or proposed position with the applicant entity. Director

9. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years.

Beginning/Ending Dates (MM/YY) 07 - 77 Employers' Name Seahurst Medical Center

Address 16110 SW 8th Bldg A-2 City Burien State/Province WA

Country USA Postal Code 98166 Phone 206-242-5280 Offices/Positions Held Internist For several years served as President

Supervisor / Contact Independent Group of Physicians Clinic Manager George Stutts

Beginning/Ending Dates (MM/YY) 1 - 95 Employers' Name Highline Medical Group

Address 15811 Ambaum Blvd. Suite A City Burien State/Province WA

Country USA Postal Code 98166 Phone 206-439-2988 Offices/Positions Held Internist

Supervisor / Contact Bert Colburn

Applicant Name John S. Van Bodegom NAIC No. _____
FEIN: _____

Beginning/Ending Dates (MM/YY) _____ - _____ Employers' Name _____

Address _____ City _____ State/Province _____

Country _____ Postal Code _____ Phone _____ Offices/Positions Held _____

Supervisor / Contact _____

Beginning/Ending Dates (MM/YY) _____ - _____ Employers' Name _____

Address _____ City _____ State/Province _____

Country _____ Postal Code _____ Phone _____ Offices/Positions Held _____

Supervisor / Contact _____

10. a. Have you ever been in a position which required a fidelity bond? NO If any claims were made on the bond, give details. _____

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked? If yes, give details. NO

11. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license (s) issued. Attach additional pages if the space provided is insufficient.

Organization/Issuer of License State of Washington Address Health Professions Quality Assurance PO Box 1099

City Olympia State/Province WA Country USA Postal Code 98507-1099

License Type Physician's License License # [redacted] Date Issued (MM/YY) 6/30/72

Date Expired (MM/YY) Expire 4/28/07 Still in force Reason for Termination _____

Non-insurance Regulatory Phone Number (if known 1-360-236-4700

Organization /Issuer of License U.S. Dept. of Justice Drug Enforcement Admin. Address Central Station, P.O. Box 28083

City Washington State/Province DC Country USA Postal Code 20038-8083

License Type Registration Cert. Controlled Substance License # [redacted] Date Issued (MM/YY) 06-30-72

Date Expired (MM/YY) 04-28-07 Reason for Termination _____

Non-insurance Regulatory Phone Number (if known) _____

Applicant Name John S. Van Bodegom

NAIC No. _____
FEIN: _____

12. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:

a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency? No

b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action? No

c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action? No

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses? No

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses? No

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses? No

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking? No

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute? No

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government? No

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity? No

If the response to any question above is answered "Yes", please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

Not Applicable

13. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. NONE

~~Hightline Services Medical Organization~~ 2013

~~Hightline Medical Services Organization~~ 2013

Applicant Name John S. Van Bodegom

NAIC No. _____
FEIN: _____

If any of the stock is pledged or hypothecated in any way, give details. None

14. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified. If the answer is "Yes", please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

NO

If any of the shares of stock are pledged or hypothecated in any way, give details.

Not Applicable

15. Have you ever been adjudged a bankrupt? NO If yes, provide details _____

16. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity? If yes, please indicate and give details. When responding to questions (b) and (c) affiant should also include any events within twelve (12) months after his or her departure from the entity.

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or Governmental-licensing agency? NO

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)? NO

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action? NO

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this _____ day of _____ 20 at _____ I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

[redacted]
(Signature of Affiant)

10/19/06
Date

State of WA County of King

The foregoing instrument was acknowledged before me this 19 day of Oct, 20 06 By

[redacted]

☐ who is personally known to me, or

☑ who produced the following identification: DL Stay

[SEAL]

Jacqueline A. Holm
Notary Public

Jacqueline A Holm
Printed Notary Name

7/9/07
My Commission Expires

STATE OF WASHINGTON
SECRETARY OF STATE

Applicant Name John S. Van Bodegom

NAIC No. _____
FEIN: _____

BIOGRAPHICAL AFFIDAVIT
Supplemental Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority.

Full Name, Address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Proposed Entity Puget Sound Health Partners, Inc.
~~Address and Telephone number not yet established~~
708 Broadway; Suite 400, Tacoma, WA 98402 253-779-8830

1. a. Affiant's Full Name (Initials Not Acceptable). John Schuyler Van Bodegom

   b. Maiden Name (if applicable) None

2. Affiant's Social Security Number [redacted]

3. Government Identification Number if not a U.S. Citizen Not Applicable

4. Foreign Student ID# (if applicable) Not Applicable

5. Date of Birth: (MM/DD/YY) [redacted] Place of Birth: City [redacted]
   State/Province [redacted] Country USA

6. Name of Affiant's Spouse (if applicable) [redacted]

7. List your residences for the last ten (10) years starting with your current address, giving:

Beginning/Ending Dates (MM/YY)	Address	City	State/ Province	Country	Postal Code
[redacted]					

Applicant Name John S. Van Bodegom

NAIC No. _____

FEIN: _____

Dated and signed this 19 day of Oct, 2006 at Highline Medical Center I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

[redacted]

(Signature of Affiant)

10/19/06

Date

State of Washington County of King

The foregoing instrument was acknowledged before me this 19th day of Oct, 20 06 By John S. Van Bodegom, and:

☒ who is personally known to me, or

☐ who produced the following identification: _____

[SEAL]

HELEN M. BROWN
COMMISSION EXPIRES
NOTARY
PUBLIC
4-28-07
STATE OF WASHINGTON

Notary Public

HELEN M. Brown

Printed Notary Name

4/28/07

My Commission Expires

Applicant Name John S. Van Bodegom

NAIC No. _____
FEIN: _____

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS(*All states except California, Minnesota and Oklahoma)*

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of Puget Sound Health Partners [*insert* **company name**]("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both)("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency ("CRA") that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact Karen Lee, Director [*insert* **company's designated person, position, or department, address and phone**].

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act."

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) twelve (12) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

[redacted]

(Signature) _____ (Date) 10/19/06

State of WA County of King

The foregoing instrument was acknowledged before me this 19th day of Oct 20 06 By John S. Van Bodegom and

☒ who is personally known to me, or

☐ who produced the following identification: _____

[SEAL]

HELEN M. BROWN NOTARY PUBLIC COMMISSION EXPIRES 4-28-07 STATE OF WASHINGTON

Helen M. Brown
Notary Public

Helen M. Brown
Printed Notary Name

4/28/07
My Commission Expires

Applicant Name Karen Lynn Lee

NAIC No. _____
FEIN: _____

BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority.

(Print or Type)

Full Name, Address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Puget Sound Health Partners, Inc.

708 Broadway; Suite 400

Tacoma, WA 98402 (253) 779-8830

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. a. Affiant's Full Name (Initials Not Acceptable). **Karen Lynn Lee** NAIC - DO MATCH

   b. Maiden Name (if applicable). **Karen Lynn Baker**

2. a. Have you ever had your name changed? **YES** If yes, give the reason for the change and provide the full name(s).
   I legally changed my last name from Baker to Lee after my second marriage in 07/2000.

   b. Other names used at any time (including aliases).

   I used Karen Lynn Baker-Braden unofficially during my first marriage from 1996-1999; no legal name change.

3. a. Are you a citizen of the United States? **YES** ✓

   b. Are you a citizen of any other country, if so, what country? **NO**

4. Affiant's Occupation or Profession. **Administrator/President**

5. Affiant's business address. **19600 International Blvd., Suite 201, Sea Tac, WA 98188**

   Business telephone. **(206) 878-1503**

Applicant Name Karen Lynn Lee

NAIC No. _____
FEIN: _____

6. Education and Training:

College/ University	City/ State	Dates Attended (MM/YY)	Degree Obtained
Clark Community College	**Vancouver, WA**	**09/85-08/87**	**AAS – Business – Accounting**
University of Washington	**Seattle, WA**	**09/88-08/90**	**BABA – Accounting**

Graduate Studies:	College/ University	City/ State	Dates Attended (MM/YY)	Degree Obtained
NONE				

Other Training: Name	City/ State	Dates Attended (MM/YY)	Degree/Certification Obtained
NONE			

(Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number in the space provided in the Biographical Affidavit Supplemental Information.)

7. List of memberships in professional societies and associations.

Name of Society/Association	Contact Name	Address of Society/Association	Telephone Number of Society/Association
NONE			

8. Present or proposed position with the applicant entity. **Director**

9. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years.

Beginning/Ending
Dates (MM/YY) **07/05 – Current** Employers'Name **Highline Medical Services Organization**

Address **19600 International Blvd.; # 201** City **SeaTac** State/Province **WA**

Country **USA** Postal Code **98188** Phone **(206) 878-1503** Offices/Positions Held **Administrator and President**

Supervisor / Contact **John Van Bodegom, M.D., Chairman of the Board of Directors**

Beginning/Ending
Dates (MM/YY) **11/96-06/05** Employers' Name **Highline Medical Center (Formerly Highline Community Hospital)**

Address **16251 Sylvester Rd. S.W.** City **Burien** State/Province **WA**

Country **USA** Postal Code **98166** Phone **(206) 244-9970** Offices/Positions Held: **11/96 Senior Accountant; 08/97 Controller; 04/98 Director of Administrative Services; 05/13/02 HMSO Administrator**

Supervisor / Contact **Mark Benedum, Chief Operating Officer**

Applicant Name Karen Lynn Lee

NAIC No. _____
FEIN: _____

Beginning/Ending
Dates (MM/YY) 01/95 - 09/96 Employers' Name Family Care, Inc.

Address 2121 S.W. Broadway, Suite 300 City Portland State/Province OR

Country USA Postal Code 97201 Phone (503) 222-2880 Offices/Positions Held Director of Finance/ C.F.O.

Supervisor / Contact Jeff Heatherington, President

Beginning/Ending
Dates (MM/YY) 02/93 – 02/95 Employers' Name Northwest Surgical Specialists, P.C. (FormerlyVancouver Orthopedic and Neurosurgical Group, Inc.)

Address 200 NE Mother Joseph Place; Suite 110 City Vancouver State/Province WA

Country USA Postal Code 98664 Phone (360) 254-6161 Offices/Positions Held Accountant, C.F.O.

Supervisor / Contact David Bennett, Administrator

Additional Pages for the rest

10. a. Have you ever been in a position which required a fidelity bond? NO If any claims were made on the bond, give details. _____

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked? If yes, give details. NO

11. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license (s) issued. Attach additional pages if the space provided is insufficient. N/A

Organization/Issuer of License _____ Address _____

City _____ State/Province _____ Country _____ Postal Code _____

License Type _____ License # _____ Date Issued (MM/YY) _____

Date Expired (MM/YY) _____ Reason for Termination _____

Non-insurance Regulatory Phone Number (if known _____

Organization /Issuer of License _____ Address _____

City _____ State/Province _____ Country _____ Postal Code _____

License Type _____ License # _____ Date Issued (MM/YY) _____

Date Expired (MM/YY) _____ Reason for Termination _____

Non-insurance Regulatory Phone Number (if known) _____

Applicant Name Karen Lynn Lee NAIC No. _____
FEIN: _____

12. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:

a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency? NO

b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action? NO

c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action? NO

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses? NO

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses? NO

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses? NO

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking? NO

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute? NO

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government? NO

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity? NO

If the response to any question above is answered "Yes", please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

13. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. NONE

Applicant Name Karen Lynn Lee

NAIC No. _____
FEIN: _____

If any of the stock is pledged or hypothecated in any way, give details. _____

14. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified. If the answer is "Yes", please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.
NO

If any of the shares of stock are pledged or hypothecated in any way, give details.

15. Have you ever been adjudged a bankrupt? **NO** If yes, provide details _____

16. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity? If yes, please indicate and give details. When responding to questions (b) and (c) affiant should also include any events within twelve (12) months after his or her departure from the entity.

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or Governmental-licensing agency? **NO**

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)? **NO**

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action? **NO**

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 23rd day of Oct. 2006 at Sea Tac I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

[redacted]
(Signature of Affiant)

10/23/06
Date

State of Washington County of King

The foregoing instrument was acknowledged before me this 23 day of October 20 06 By

[redacted], and:

☒ who is personally known to me, or

☐ who produced the following identification: _____

[SEAL]
MARGARET A. EATON
COMMISSION EXPIRES
NOTARY
PUBLIC
JUNE 18, 2007
STATE OF WASHINGTON

Margaret A. Eaton
Notary Public

Margaret A. Eaton
Printed Notary Name

June 18, 07
My Commission Expires

Applicant Name Karen Lynn Lee

NAIC No. _____
FEIN: _____

BIOGRAPHICAL AFFIDAVIT
Supplemental Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority.

Full Name, Address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Puget Sound Health Partners, Inc.

708 Broadway; Suite 400

Tacoma, WA 98402 (253) 779-8830

1. a. Affiant's Full Name (Initials Not Acceptable). **Karen Lynn Lee**

   b. Maiden Name (if applicable) **Karen Lynn Baker**

2. Affiant's Social Security Number [redacted]

3. Government Identification Number if not a U.S. Citizen **N/A**

4. Foreign Student ID# (if applicable) **N/A**

5. Date of Birth: (MM/DD/YY) [redacted] lace of Birth: City [redacted]
   State/Province **Oregon** Country **USA**

6. Name of Affiant's Spouse (if applicable) [redacted]

7. List your residences for the last ten (10) years starting with your current address, giving:

Beginning/Ending Dates (MM/YY)	Address	City	State/ Province	Country	Postal Code
12/00 – Current	[redacted]				
05/99 – 12/00					
09/96 – 05/99					

Applicant Name Karen Lynn Lee

NAIC No. _____
FEIN: _____

Dated and signed this 23rd day of October, 2006 at SeaTac I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

[redacted]
(Signature of Affiant)

10/23/06
Date

State of Washington County of King

The foregoing instrument was acknowledged before me this 23 day of October, 20 06 By

[redacted]nd:

☒ who is personally known to me, or

☐ who produced the following identification: _____

MARGARET A. EATON
COMMISSION EXPIRES
NOTARY
PUBLIC
JUNE 18, 2007
STATE OF WASHINGTON

Margaret A. Eaton
Notary Public

Margaret A. Eaton
Printed Notary Name

June 18, 07
My Commission Expires

Applicant Name Karen Lynn Lee

NAIC No. _____
FEIN: _____

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS*(All states except California, Minnesota and Oklahoma)*

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of **Puget Sound Health Partners, Inc.** ("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both)("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency ("CRA") that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact **Karen Lee, Director, Puget Sound Health Partners, 708 Broadway; Suite 400, Tacoma, WA 98402; (253) 779-8830.**

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act."

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) twelve (12) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

Karen Lynn Lee 38009 34th Ct. S. Auburn, WA 98001
(Printed Full Name and Residence Address)

[redacted]
(Signature)

10/23/06
(Date)

State of WA County of King

The foregoing instrument was acknowledged before me this 23 day of October 20 06 By [redacted] and

☒ who is personally known to me, or

☐ who produced the following identification: _____

[SEAL]

MARGARET A. EATON
COMMISSION EXPIRES
NOTARY
PUBLIC
JUNE 18, 2007
STATE OF WASHINGTON

Margaret A. Eaton
Notary Public

Margaret A. Eaton
Printed Notary Name

June 18, 07
My Commission Expires

Attachment 9.) Additional Employment

Beginning/Ending
Dates (MM/YY) **02/91 – 02/93** Employers' Name **R.A. Barnes, Inc.**

Address **Company no longer exists; was located in** City **Seattle** State/Province **WA**

Country **USA** Postal Code ___ Phone_____ Offices/Positions Held: **Assistant Controler, Operations Manager,**

Supervisor / Contact **John Jones, Controller**

Beginning/Ending
Dates (MM/YY) **02/90 – 02/91** Employers' Name **Industrial Technologies**

Address **Company no longer exists; was located at 5811 6th Ave. South** City **Seattle** State/Province **W A**

Country **USA** Postal Code **98108** Phone_____ Offices/Positions Held **Staff Accountant**

Supervisor / Contact **John Jones, Accounting Manager**

Marshall McGinnis

From: Howard Thomas [HTConsulting@comcast.net]
Sent: Friday, December 22, 2006 2:15 PM
To: Marshall McGinnis
Subject: Pat Briggs and Karen Lee

Marshall;

Here is another letter to help clear up the incidents that came up on the background checks for Pat Briggs and Karen Lee.

Pat Briggs was in fact Patricia Sparks many years ago. She was married and legally changed her name in 1967. Hopefully that clears that up for you.

Karen Lee was in fact Karen Baker. She did tell me that there was a lawsuit involving a motor vehicle accident and that her former husband was the driver and she was a named defendant. She indicated that this matter was taken over by their insurance company and the matter was resolved by them. This one should be closed.

She was married to her current husband and changed her name form Baker to Lee in July of 2000. Hopefully that helps to clear up the second lawsuit that you had mentioned which I presume was more recent than that. If you need additional info on any of this please let me know.

Sincerely,
Howard Thomas

Thomas & Associates Consulting, L.L.C.
425/888-4399
HTConsulting@comcast.net

Applicant Name Schadt, Laurence Conrad

NAIC No. _____
FEIN: _____

BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority.

(Print or Type)

Full Name, Address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names). Puget Sound Health Partners, Inc.
708 Broadway, Suite 400
Tacoma, WA. 98402
(253) 779-8830

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. a. Affiant's Full Name (Initials Not Acceptable). Laurence Conrad Schadt

   b. Maiden Name (if applicable). NAIC - DO MATCH

2. a. Have you ever had your name changed? no If yes, give the reason for the change and provide the full name(s).
   N/A

   b. Other names used at any time (including aliases).
   my name has been misspelled "Lawrence Schadt".
   use also "Larry Schadt", "Laurence C. Schadt"

3. a. Are you a citizen of the United States? yes

   b. Are you a citizen of any other country, if so, what country? no

4. Affiant's Occupation or Profession. Physician

5. Affiant's business address. 3622 A Ensign Rd., N.E., Olympia, Wa, 98506

   Business telephone. 360 459-7282

Applicant Name Schadt, Laurence Conrad

NAIC No. _____
FEIN: _____

6. Education and Training:

College/ University	City/ State	Dates Attended (MM/YY)	Degree Obtained
Stanford University	Stanford, Calif	09/68 - 06/72	BS

Graduate Studies: College/ University	City/ State	Dates Attended (MM/YY)	Degree Obtained
Univ. Calif. Los Angeles	Los Angeles, Calif	09/72 - 6/77 *	MD

* leave of absence 7/73 - 8/74

Other Training: Name	City/ State	Dates Attended (MM/YY)	Degree/Certification Obtained
Internship/Residency Natividad Med. Center	Salinas, Calif	06/77 - 06/80	Family Practice Residency

(Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number in the space provided in the Biographical Affidavit Supplemental Information.)

7. List of memberships in professional societies and associations.

Name of Society/Association	Contact Name	Address of Society/Association	Telephone Number of Society/Association
Thurston-Mason County Med. Society	Susan Peterson	1800 Cooper Pt. Rd., S.W. Bldg 7A	
Washington State Medical Association (Thurston-Mason County Med Society Serves as local liason for Wa-St. Med. Assoc.)	" "	" "	(360) 352-1417

8. Present or proposed position with the applicant entity. Board Member, Board of Directors.

9. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years.

Beginning/Ending Dates (MM/YY) 07/91 - present Employers' Name Olympia Family Medicine

Address 3622A Ensign Rd, N.E. City Olympia State/Province WA

Country USA Postal Code 98506 Phone 360 459-7282 Offices/Positions Held Physician

Supervisor / Contact Chris Curtis

Beginning/Ending Dates (MM/YY) 06/01 - 01/04 Employers' Name Spectrum Healthcare Resources

Address 12647 Olive Blvd. Suite 600 City St. Louis State/Province MO

Country USA Postal Code 63141 Phone 1-800-325-3982 Offices/Positions Held Contract Physician. Bremerton Naval Hospital Bremerton, WA

Supervisor / Contact "Donna" best is Fax (314) 744-4180

Applicant Name Schadt, Laurence Conrad NAIC No. _____ FEIN: _____

Beginning/Ending Dates (MM/YY) 02/92 - 12/97 Employers' Name Coastal Emergency Physians, Inc. (of Texas)
See Attached "Addendum Page 3"

Address _____ City _____ State/Province _____

Country _____ Postal Code _____ Phone _____ Offices/Positions Held Contract Physician Capital Medical Center Olympia, Wa

Supervisor / Contact See Attached "Addendum Page 3"

Beginning/Ending Dates (MM/YY) _____ - _____ Employers' Name See Attached "Addendum Page 3"

Address _____ City _____ State/Province _____

Country _____ Postal Code _____ Phone _____ Offices/Positions Held _____

Supervisor / Contact _____

10. a. Have you ever been in a position which required a fidelity bond? no If any claims were made on the bond, give details. _____

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked? If yes, give details. no

11. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license (s) issued. Attach additional pages if the space provided is insufficient.

Organization/Issuer of License Wa. St. Dept. Health Address Health Professions Quality Assurance Customer Service Center P.O. Box 47865, ~~Olympia, Wa 98504~~ (LC)

City Olympia State/Province WA Country USA Postal Code 98504

License Type Physician License # [redacted] Date Issued (MM/YY) 04/2006 (first issue circa 05/88)

Date Expired (MM/YY) N/A Reason for Termination N/A

Non-insurance Regulatory Phone Number (if known (360) 236-4700

Organization /Issuer of License Drug Enforcement Admin. Address 400 2nd Ave. West

City Seattle State/Province Wa Country USA Postal Code 98119

License Type DEA License # [redacted] Date Issued (MM/YY) 02/05 (first issue circa 10/78)

Date Expired (MM/YY) N/A Reason for Termination N/A

Non-insurance Regulatory Phone Number (if known) 1 888 219-1418

(See Attached "Addendum Page 3"

Applicant: Schadt, Laurence Conrad

ADDENDUM PAGE 3

Employment (cont'd)

02/92 - 12/97 Coastal Emergency Physicians, Inc (of Texas) seems no longer to be in existence. Best information likely would be through the Medical Staff office in the hospital wherein I was contracted (by Coastal) to provide emergency physician services:
Capital Medical Center
3900 Capital Mall Dr., S.W.
Olympia, WA 98502
(360) 754-5858 - ask for Medical Staff Secretary

07/91 - 06/92 Group Health Cooperative (of Washington) Locum Tenens
Attn: credentialling
P.O. Box 34262
Seattle, WA 98124
(Voice 206 988-2072)
they suggest Fax 206 988-2084 Attn: Bernie

06/89 - 06/91 Group Health Cooperative (of Washington) full-time Urgent Care
see above for contact information

07/89 - 08/89 Spectrum Healthcare Resources (contract emergency physician services, Lakewood [now St. Clair] Hospital, Lakewood, WA)
see contact information page 3

02/89 - 06/89 Scenic General Hospital - the county hospital for Stanislaus County, has since closed. Employment/Privileging records have been assumed by:
Health Services Agency, Stanislaus County,
Attn: Administration
P.O.Box 3271
Modesto, CA 95353
(209) 558-7000 option 9 (administration)

12/87 - 02/89 Contract Emergency Physician, Scenic General Hospital. "Holbrook & Associates" (of San Francisco, CA, no longer seem to be in business - best contact information see above "Scenic General Hospital")

12/84 - 12/87 Faculty, Family Practice Residency, Merced, California
formerly: Merced Community Medical Center
now: Mercy Medical Center Merced
315 East 13th Street
Merced, CA 95340
(209) 385-7172 attn: Aletha

License(s) (cont'd):

Issuer: Med. Brd. of California *Address:* 1426 Howe Ave., Suite 54
City: Sacramento *State:* CA *Country:* USA *Postal Code:*95825-3236
License Type: Physician *License #:* G37574 *Status:* Lapsed circa 5/90 - I did not renew after moving to Olympia, WA. First Issued circ 08/78, renewed annually/biannually until lapsed.
(916) 263-2382

Applicant Name Schadt, Laurence Conrad NAIC No. _____
FEIN: _____

12. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:

a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency? no

b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action? no

c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action? no

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses? no

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses? no

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses? no

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking? no

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute? no

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government? no

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity? no

If the response to any question above is answered "Yes", please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

N/A

13. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. N/A

Applicant Name Schadt, Laurence Conrad

NAIC No. _____
FEIN: _____

If any of the stock is pledged or hypothecated in any way, give details. N/A

14. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified. If the answer is "Yes", please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

no

If any of the shares of stock are pledged or hypothecated in any way, give details.

no

15. Have you ever been adjudged a bankrupt? no If yes, provide details N/A

16. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity? If yes, please indicate and give details. When responding to questions (b) and (c) affiant should also include any events within twelve (12) months after his or her departure from the entity.

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or Governmental-licensing agency? no

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

no

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action? no

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this _____ day of _____ 20 at _____ I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

[redacted]
(Signature of Affiant)

10/26/06
Date

State of Washington County of Thurston

The foregoing instrument was acknowledged before me this 26th day of Oct., 2006 By Christine Curtis, and:

☒ who is personally known to me, or

☐ who produced the following identification: _____

[SEAL]

Christine Curtis
Notary Public

Christine Curtis
Printed Notary Name

2-01-09
My Commission Expires

Applicant Name Schadt, Laurence Conrad

NAIC No. _____
FEIN: _____

BIOGRAPHICAL AFFIDAVIT
Supplemental Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority.

Full Name, Address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Puget Sound Health Partners, Inc.
708 Broadway, Suite 400
Tacoma, Wa 98402

1. a. Affiant's Full Name (Initials Not Acceptable). Laurence Conrad Schadt
   b. Maiden Name (if applicable) N/A
2. Affiant's Social Security Number [redacted]
3. Government Identification Number if not a U.S. Citizen N/A
4. Foreign Student ID# (if applicable) N/A
5. Date of Birth: (MM/DD/YY) [redacted] Place of Birth: City [redacted]
   State/Province [redacted] Country USA
6. Name of Affiant's Spouse (if applicable) [redacted]
7. List your residences for the last ten (10) years starting with your current address, giving:

Beginning/Ending Dates (MM/YY)	Address	City	State/ Province	Country	Postal Code
[redacted]					(USA)
[redacted]					(USA)

Applicant Name Schadt, Laurence Conrad

NAIC No. _____

FEIN: _____

Dated and signed this 26th day of October, 2006 at Olympia, Washington I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

[redacted]

(Signature of Affiant)

10/26/06

Date

State of Washington County of Thurston

The foregoing instrument was acknowledged before me this 26th day of Oct, 2006 By Christine Curtis, and:

☒ who is personally known to me, or

☐ who produced the following identification: _____

[SEAL]

Christine Curtis

Notary Public

Christine Curtis

Printed Notary Name

2-01-09

My Commission Expires

Applicant Name Schadt, Laurence Conrad

NAIC No. _____
FEIN: _____

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS*(All states except California, Minnesota and Oklahoma)*

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of Puge Sound Health Partners. [*insert* **company name**]("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both)("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency ("CRA") that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact [*insert* **company's designated person, position, or department, address and phone**].

[redacted]

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act."

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) twelve (12) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

[redacted]
(Printed Full Name and Residence Address)

[redacted]
(Signature)

10/26/06
(Date)

State of Wash County of Thurston

The foregoing instrument was acknowledged before me this 26th day of Oct 20 06 By Christine Curtis, and

☒ who is personally known to me, or

☐ who produced the following identification: _____

[SEAL]

Christine Curtis
Notary Public

Christine Curtis
Printed Notary Name

2-01-09
My Commission Expires

Applicant Name Schadt, Laurence Conrad

NAIC No. _____

FEIN: _____

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS (*Minnesota and Oklahoma*)

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of Puget Sound Health Partners [*insert* **company name**]("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both)("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may request more information about the nature and scope of Background Reports produced by any consumer reporting agency ("CRA") by submitting a written request to Company. You should submit any such written request for more information, to _____ [*insert* **company's designated person, position, or department, address and phone**].

[redacted]

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act." You will be provided with a copy of any Background Report procured by Company if you check the box below.

☒ By checking this box, I request a copy of any Background Report from any CRA retained by Company, at no extra charge.

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) twelve (12) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

Laurence Conrad Schadt, [redacted]

(Printed Full Name and Residence Address)

[redacted] 10/26/06

(Signature) (Date)

State of WASH County of Thurston

The foregoing instrument was acknowledged before me this 26th day of Oct, 2006 By Christine Curtis, and

☒ who is personally known to me, or

☐ who produced the following identification: _____

[SEAL]

Christine Curtis

Notary Public

Christine Curtis

Printed Notary Name

2-01-09

My Commission Expires

Applicant Name Schadt, Laurence Conrad

NAIC No. _____

FEIN: _____

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS (*California*)

This Disclosure and Authorization is provided to you in connection with a pending application of Puget Sound Health Partners, Inc. **[*insert* company name]**("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both)("Background Reports") regarding your background for review by any department of insurance in such states where Company is currently pursuing an Application, because you are either functioning as, or are seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports will be obtained through _____ **[*insert* name of CRA, address]**("CRA"). Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may request more information about the nature and scope of Background Reports produced by any consumer reporting agency ("CRA") by submitting a written request to Company. You should submit any such written request for more information, to [redacted] **[*insert* company's designated person, position, or department, address and phone]**. [redacted]

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act." You will be provided with a copy of any Background Report procured by Company if you check the box below.

☐ By checking this box, I request a copy of any Background Report from any CRA retained by Company, at no extra charge.

Under section 1786.22 of the California Civil Code, you may view the file maintained on you by the CRA listed above. You may also obtain a copy of this file, upon submitting proper identification and paying the costs of duplication services, by appearing at the CRA in person or by mail; you may also receive a summary of the file by telephone. The CRA is required to have personnel available to explain your file to you and the CRA must explain to you any coded information appearing in your file. If you appear in person, you may be accompanied by one other person of your choosing, provided that person furnishes proper identification.

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. In no event, however, will this authorization remain in effect beyond twelve (12) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

[redacted]

(Printed Full Name and Residence Address)

[redacted] 10/26/06

(Signature) (Date)

State of WASH. County of Thurston

The foregoing instrument was acknowledged before me this 26th day of Oct, 20 06 By Christine Curtis, and

☒ who is personally known to me, or

☐ who produced the following identification: _____

[SEAL]

Christine Curtis

Notary Public

Christine Curtis

Printed Notary Name

2-01-09

My Commission Expires

Applicant Name Leonard B. Alenick, MD

RECEIVED
OCT 23 2005

NAIC No.
FEIN:

BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority.

(Print or Type)

Full Name, Address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Puget Sound Health Partners
708 Broadway #400
Tacoma, WA 98402
(253) 779-8830

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. a. Affiant's Full Name (Initials Not Acceptable). Leonard Bennett Alenick, MD

   NAIC - DO MATCH

   b. Maiden Name (if applicable). N/A

2. a. Have you ever had your name changed? No If yes, give the reason for the change and provide the full name(s). N/A

   b. Other names used at any time (including aliases). Len Alenick; Lenny Alenick

3. a. Are you a citizen of the United States? Yes ✓

   b. Are you a citizen of any other country, if so, what country? N/A

4. Affiant's Occupation or Profession. Physician

5. Affiant's business address. 5920 100th Street SW; Suite 33; Lakewood WA 98499-2751

   Business telephone. 253-582-0525

Applicant Name Leonard B. Alenick, MD

NAIC No. _____
FEIN: _____

6. Education and Training:

College/ University	City/ State	Dates Attended (MM/YY)	Degree Obtained
Gettysburg College	Gettysburg PA	09/57 - 06/61	BA

Graduate Studies:	College/ University	City/ State	Dates Attended (MM/YY)	Degree Obtained
Johns Hopkins University	School of Medicine	Baltimore MD	09/61 - 06/65	MD

Other Training: Name	City/ State	Dates Attended (MM/YY)	Degree/Certification Obtained
Long Island Jewish Med. Center;	New Hyde Park NY	07/65 – 06/66	Rotating Internship
Brooklyn Eye & Ear Hospital;	Brooklyn NY	07/69 – 06/72	Ophthalmology Residency

(Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number in the space provided in the Biographical Affidavit Supplemental Information.) N/A

7. List of memberships in professional societies and associations.

Name of Society/Association	Contact Name	Address of Society/Association	Telephone Number of Society/Association
American Medical Association	Membership Department	515 N. State Street Chicago, IL 60610	(800) 621-8335
American Academy of Ophthalmology	Membership Department	P.O. Box 7424 San Francisco, CA 94120-7424	415.561.8500
Washington State Medical Association	Membershjp Department	2033 6th Ave., Suite 1100 Seattle, Washington 98121	206-441-9762

Wa. Academy of Eye Physicians & Surgeons; Kory Diemert; 2033 6th Ave. Suite 1100; Seattle WA 98121; 206-441-9762
Pierce County Medical Society; Sue Asher; 223 Tacoma Ave. S; Tacoma WA 98402; 253) 572-3667

8. Present or proposed position with the applicant entity. Board Member ✓

9. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years.

Beginning/Ending
Dates (MM/YY): 07/72- present Employers'Name: Leonard B Alenick, MD (self)

Address: 5920 100th St SW; Lakewood WA 98499-2751

Country: USA_____ Postal Code: 98499-2751 Phone: 253-582-0525 Offices/Positions Held: owner/Physician

Supervisor / Contact: self

Beginning/Ending
Dates (MM/YY): 12/97- present Employers' Name: Western State Hospital
Address: 9601 Steilacoom Blvd. City: Lakewood State/Province: WA

Countr:y USA_____ Postal Code: 98498 ____ Phone 253-582-8900 Offices/Positions Held: contracted provider

Supervisor / Contact: Dr. Donald Liteanu _____

Applicant Name Leonard B. Alenick, MD NAIC No. _____
FEIN: _____

Beginning/Ending
Dates (MM/YY)_____ - _____ Employers'Name N/A

Address _____ City _____ State/Province _____

Country _____ Postal Code _____ Phone _____ Offices/Positions Held _____

Supervisor / Contact _____

Beginning/Ending
Dates (MM/YY)_____ - _____ Employers'Name N/A

10. a. Have you ever been in a position which required a fidelity bond? Yes ✓ _____ If any claims were made on the bond, give details. None ✓ _____

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked? If yes, give details. No ✓ _____

11. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license (s) issued. Attach additional pages if the space provided is insufficient.

Organization/Issuer of License: WA State Dept. Health Address: Health Professions Quality Assurance; 310 Israel Rd.

City: Tumwater_____ State/Province: WA _____ Country: USA _____ Postal Code: 98501 _____

License Type: Physician and Surgeon License #: [redacted] Date Issued (MM/YY) 06/68 _____

Date Expired (MM/YY): N/A renewal due 06/11/2008 Reason for Termination: N/A _____

Non-insurance Regulatory Phone Number (if known): (360) 236 - 4700 _____

Organization /Issuer of License: Medical Board of California Address: 1426 Howe Avenue, Suite 54

City: Sacramento _____ State/Province: CA _____ Country: USA_____ Postal Code: 95825-3236

License Type: Physician & Surgeon License # : [redacted] _____ Date Issued (MM/YY): 07/21/1971 _____

Date Expired (MM/YY) mid 1980's _____ Reason for Termination : Decision to not pay yearly dues because of no desire to practice in CA

Non-insurance Regulatory Phone Number (if known): (916) 263-2382 _____

Organization /Issuer of License: New York State Education Department; Office of the Professions
Address: State Education Building - 2nd floor; 89 Washington Avenue

City: Albany State/Province: NY Country: USA ___ Postal Code: 12234

License Type: Medicine License # [redacted] _____ Date Issued (MM/YY): 07/11/66

Date Expired (MM/YY) 1980's _____ Reason for Termination: Decision to not pay renewal fees because of no desire to practice in NY. Current status is "Not Registered" which is defined as I didn't renew it
Non-insurance Regulatory Phone Number (if known): 518-474-3817 _____

Applicant Name Leonard B. Alenick, MD

NAIC No. _____
FEIN: _____

12. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:

a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency? No

b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action? No

c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action? No

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses? No

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses? No

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses? No

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking? No

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute? No

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government? No

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity? No

If the response to any question above is answered "Yes", please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

N/A

13. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. N/A

Applicant Name Leonard B. Alenick, MD

NAIC No. _____
FEIN: _____

If any of the stock is pledged or hypothecated in any way, give details. N/A

14. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified. If the answer is "Yes", please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities. N/A

If any of the shares of stock are pledged or hypothecated in any way, give details. N/A

15. Have you ever been adjudged a bankrupt? No ✓ If yes, provide details N/A

16. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity? If yes, please indicate and give details. When responding to questions (b) and (c) affiant should also include any events within twelve (12) months after his or her departure from the entity.

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or Governmental-licensing agency? No ✓

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)? Yes. See Addendum

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action? No ✓

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 20th day of Oct 2006 at Lakewood I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

[redacted]
(Signature of Affiant)

10/20/06
Date

State of Washington County of Pierce

The foregoing instrument was acknowledged before me this 20th day of Oct, 20 06 By Leonard B Alenick, and:

☐ who is personally known to me, or

☒ who produced the following identification: WA State Drivers License

JOSHUA S HOLMES
Notary Public
State of Washington
My Commission Expires
April 13, 2010

[SEAL]

Notary Public

Joshua S Holmes
Printed Notary Name

April 13 2010
My Commission Expires

Applicant Name Leonard B. Alenick, MD

NAIC No. _____
FEIN: _____

BIOGRAPHICAL AFFIDAVIT
Supplemental Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority.

Full Name, Address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).). Puget Sound Health Partners
708 Broadway #400
Tacoma, WA 98402
(253) 779-8830

1. a. Affiant's Full Name (Initials Not Acceptable). Leonard Bennett Alenick, MD
   b. Maiden Name (if applicable) N/A
2. Affiant's Social Security Number [redacted]
3. Government Identification Number if not a U.S. Citizen N/A
4. Foreign Student ID# (if applicable) N/A
5. Date of Birth: (MM/DD/YY) [redacted] Place of Birth: City: [redacted]
   State/Province [redacted] Country Kings
6. Name of Affiant's Spouse (if applicable) Gail Shindell Alenick
7. List your residences for the last ten (10) years starting with your current address, giving:

Beginning/Ending Dates (MM/YY)	Address	City	State/ Province	Country	Postal Code
[redacted]					
N/A					

Applicant Name Leonard B. Alenick, MD

NAIC No. _____
FEIN: _____

Dated and signed this 20th day of Oct., 2006 at Lakewood WA I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

[redacted]
(Signature of Affiant)

10/20/06
Date

State of Washington County of Pierce

The foregoing instrument was acknowledged before me this 20th day of Oct, 2006 By Leonard B Alenick, and:

☐ who is personally known to me, or

☒ who produced the following identification: WA State Drivers License

JOSHUA S HOLMES
Notary Public
State of Washington
My Commission Expires
April 13, 2010
[SEAL]

Notary Public

Joshua S Holmes
Printed Notary Name

April 13 2010
My Commission Expires

Applicant Name Leonard B. Alenick, MD

NAIC No. _____
FEIN: _____

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS(*All states except California, Minnesota and Oklahoma)*

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of **_To Be Determined](“Company”)** for licensure or a permit to organize (“Application”) with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both)(“Background Reports”) regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative (“Affiant”) of Company or of any business entities affiliated with Company (“Term of Affiliation”) for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency (“CRA”) that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact _____**[*insert* company’s designated person, position, or department, address and phone].**

Attached for your information is a “Summary of Your Rights Under the Fair Credit Reporting Act.”

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) twelve (12) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.
Leonard Bennett Alenick MD; [redacted]

[redacted]
(Signature)

10/20/06
(Date)

State of WA County of Pierce

The foregoing instrument was acknowledged before me this 20th day of Oct 20 06 By Leonard B Alenick, and

☐ who is personally known to me, or

☒ who produced the following identification: WA Drivers License

JOSHUA S HOLMES
[SEAL] Notary Public
State of Washington
My Commission Expires
April 13, 2010

Joshua S Holmes
Notary Public

Joshua S Holmes
Printed Notary Name

April 13 2010
My Commission Expires

Applicant Name Leonard B. Alemick, MD

NAIC No. _____

FEIN: _____

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS (*Minnesota and Oklahoma*)

N/A

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of PUGET SOUND HEALTH PARTNERS [*insert* ~~company name~~]("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both)("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may request more information about the nature and scope of Background Reports produced by any consumer reporting agency ("CRA") by submitting a written request to Company. You should submit any such written request for more information, to _____ [*insert* **company's designated person, position, or department, address and phone**].

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act." You will be provided with a copy of any Background Report procured by Company if you check the box below.

☐ By checking this box, I request a copy of any Background Report from any CRA retained by Company, at no extra charge.

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) twelve (12) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

_____
(Printed Full Name and Residence Address)

N/A [redacted] 10/20/06
(Date)

State of WA County of Pierce

The foregoing instrument was acknowledged before me this 20th day of Oct, 2006 By Leonard B Alemch, and

☐ who is personally known to me, or

☒ who produced the following identification: WA State Drivers License

[SEAL] JOSHUA S HOLMES
Notary Public
State of Washington
My Commission Expires
April 13, 2010

Notary Public

Joshua S Holmes
Printed Notary Name

April 13 2010
My Commission Expires

Applicant Name Leonard B. Alenick, MD

NAIC No. _____
FEIN: _____

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS (*California*) N/A

This Disclosure and Authorization is provided to you in connection with a pending application of PUGET SOUND HEALTH PARTNERS [~~*insert* company name~~]("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both)("Background Reports") regarding your background for review by any department of insurance in such states where Company is currently pursuing an Application, because you are either functioning as, or are seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports will be obtained through _____[*insert* **name of CRA, address**]("CRA"). Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may request more information about the nature and scope of Background Reports produced by any consumer reporting agency ("CRA") by submitting a written request to Company. You should submit any such written request for more information, to _____[*insert* **company's designated person, position, or department, address and phone**].

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act." You will be provided with a copy of any Background Report procured by Company if you check the box below.

☐ By checking this box, I request a copy of any Background Report from any CRA retained by Company, at no extra charge.

Under section 1786.22 of the California Civil Code, you may view the file maintained on you by the CRA listed above. You may also obtain a copy of this file, upon submitting proper identification and paying the costs of duplication services, by appearing at the CRA in person or by mail; you may also receive a summary of the file by telephone. The CRA is required to have personnel available to explain your file to you and the CRA must explain to you any coded information appearing in your file. If you appear in person, you may be accompanied by one other person of your choosing, provided that person furnishes proper identification.

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. In no event, however, will this authorization remain in effect beyond twelve (12) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

~~N/A~~ [redacted] 10/20/06
(Date)

State of WA County of King

The foregoing instrument was acknowledged before me this 20th day of Oct, 2006 By Leonard B Alenick and

☐ who is personally known to me, or

☒ who produced the following identification: WA state Drivers license

[SEAL] JOSHUA S HOLMES
Notary Public
State of Washington
My Commission Expires
April 13, 2010

Notary Public

Joshua S Holmes
Printed Notary Name

April 13 2010
My Commission Expires

Leonard B. Alenick, M.D.

Addendum to Question 16b:

I was the Vice Chair of the Board of Unified Physicians of Washington (UPW), a health care services contractor. UPW was incorporated on February 5, 1994 with subsequent initial capitalization a stock offering to physicians and the sale of stock to two health related insurers.

The UPW business plan was based on allowing approximately 40 Independent Practice Associations (IPAs) and Physician Hospital Organizations (PHOs) to have individual contracts with individual fee schedules and payment methodologies. This approach was adopted when UPW management found that Northwestern Mutual Life, a Fortune 500 company, had a Third Party Administrator (TPA) subsidiary that appeared to demonstrate the computer ability to service this complex arrangement, and contractually committed to do so.

When UPW went operational with a Medicaid Managed Care contract, it was quickly discovered that the TPA did not have the promised capability and was hand processing claims with a high rate of late payments, overpayments and multiple payments of claims. The TPA had several management changes in 18 months.

UPW sought a replacement TPA but there was none available that could service the company's complex payment commitments. Eventually, Kitsap Physicians Service (KPS) took over the TPA business with the full understanding that computer technology was unavailable to fulfill UPW's payment methodology. KPS did a far better job than the original TPA but the flawed contractual arrangements committed the company to a course that was not sustainable. UPW negotiated a $3,000,000 out of court settlement from Northwestern Mutual Life for not fulfilling its part of the contract but the funds were inadequate to maintain UPW's statutory reserve requirements and cover operating expenses.

In the late summer of 1997 members of the UPW Board and the state's Office of the Insurance Commissioner (OIC) negotiated a unique business partnership, approved in Thurston County Superior Court, in an effort to stabilize the company. This was not possible, and the company processed its contractual claims obligations through May 15, 1998 when it was released to the OIC for final liquidation. Subscribers of the company were made whole in the process. The company's shareholders, as unsecured creditors, took a loss on their stock investments.

No assertions of fraud, dishonesty or malfeasance were directed at UPW management or the company's Board of Directors.

Applicant Name **Lloyd Richard Musselman, Jr.**

NAIC No. _____
FEIN: _____

BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority.

(Print or Type)

Full Name, Address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Puget Sound Health Partners, Inc.
708 Broadway, Suite 400
Tacoma, Washington 98402
253-779-8830

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. a. Affiant's Full Name (Initials Not Acceptable). **Lloyd Richard Musselman, Jr.** NAIC –

   b. Maiden Name (if applicable). **N/A** NO MATCH

2. a. Have you ever had your name changed? **NO** If yes, give the reason for the change and provide the full name(s).

   b. Other names used at any time (including aliases).

   Nickname: Bud

3. a. Are you a citizen of the United States? **YES**

   b. Are you a citizen of any other country, if so, what country? **N/A**

4. Affiant's Occupation or Profession. **Chief Financial Officer**

5. Affiant's business address. **16251 Sylvester Rd. S.W. Burien, WA 98166**

   Business telephone. **(206)-461-5235**

Applicant Name **Lloyd Richard Musselman, Jr.** NAIC No. _____
FEIN: _____

6. Education and Training:

College/ University	City/ State	Dates Attended (MM/YY)	Degree Obtained
Pennsylvania College of Technology	**Williamsport, PA**	**(09/71-06/74)**	**Associate Degree**
Bloomsburg University of Pennsylvania	**Bloomsburg, PA**	**(09/81-06/83)**	**BSBA Degree**

Graduate Studies:	College/ University	City/ State	Dates Attended (MM/YY)	Degree Obtained
Business Administration	**Wilkes University**	**Wilkes-Barre, PA**	**(09/84-06/87)**	**MBA Degree**

Other Training: Name	City/ State	Dates Attended (MM/YY)	Degree/Certification Obtained

(Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number in the space provided in the Biographical Affidavit Supplemental Information.)

7. List of memberships in professional societies and associations.

Name of Society/Association	Contact Name	Address of Society/Association	Telephone Number of Society/Association
American College of Healthcare Executives	**Cynthia Hahn**	**Suite 1700 One North Franklin Street, Chicago, Illinois 60606**	**312-424-2800**
Healthcare Financial Management Association	**Steve Rauchenecker**	**Two Westbrook Corporate Center, Suite 700 Westchester, IL 60154**	**708-531-9600**

8. Present or proposed position with the applicant entity. **Director**

9. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years.

Beginning/Ending
Dates (MM/YY) **(08/99) - Present** Employers'Name **Highline Medical Center**

Address **16251 Sylvester Rd. S.W.** City **Burien** State/Province **WA**

Country **USA** Postal Code **98166** Phone **206-431-5235** Offices/Positions Held **CFO**

Supervisor / Contact **Paul Tucker, CEO**

Beginning/Ending
Dates (MM/YY) **(01/95) - (06/99)** Employers' Name **Brim Healthcare (Portland, OR office)**

Address **105 Westwood Place Suite 300** City **Brentwood** State/Province **TN**

Country **USA** Postal Code **37027** Phone **615-309-6053** Offices/Positions Held Vice-President
Supervisor / Contact **Dave Woodland, CEO**

Applicant Name **Lloyd Richard Musselman, Jr.** NAIC No. _____
FEIN: _____

Beginning/Ending
Dates (MM/YY) **(12/91) – (12/94)** Employers'Name **Dunwoody Medical Center**

Address **4575 North Shallowford Road** City **Atlanta** State/Province **GA**

Country **USA** Postal Code **30338** Phone **(770) 454-2000** Offices/Positions Held **Chief Financial Officer**

Supervisor / Contact **Tom Gilbert , CEO**

Beginning/Ending
Dates (MM/YY) **(06/80) – (12/91)** Employers'Name **Berwick Healthcare Center**

Address 701 east 16th St. City **Berwick** State/Province **PA**

Country **USA** Postal Code **18603** Phone **(570) 759-5000** Offices/Positions Held **Vice President - Finance**

Supervisor / Contact **Terry John, CEO**

10. a. Have you ever been in a position which required a fidelity bond? **NO** If any claims were made on the bond, give details. _____

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked? If yes, give details. **NO**

11. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license (s) issued. Attach additional pages if the space provided is insufficient. **NONE**

Organization/Issuer of License _____ Address _____

City _____ State/Province _____ Country _____ Postal Code _____

License Type _____ License # _____ Date Issued (MM/YY) _____

Date Expired (MM/YY) _____ Reason for Termination _____

Non-insurance Regulatory Phone Number (if known _____

Organization /Issuer of License _____ Address _____

City _____ State/Province _____ Country _____ Postal Code _____

License Type _____ License # _____ Date Issued (MM/YY) _____

Date Expired (MM/YY) _____ Reason for Termination _____

Non-insurance Regulatory Phone Number (if known) _____

Applicant Name **Lloyd Richard Musselman, Jr.** NAIC No. _____
FEIN: _____

12. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:

    a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency? **NO**

    b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action? **NO**

    c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action? **NO**

    d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses? **NO**

    e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses? **NO**

    f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses? **NO**

    g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking? **NO**

    h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute? **NO**

    i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government? **NO**

    j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity? **NO**

    If the response to any question above is answered "Yes", please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

13. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. **NONE**

Applicant Name **Lloyd Richard Musselman, Jr.** NAIC No. _____
FEIN: _____

If any of the stock is pledged or hypothecated in any way, give details. _____

14. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified. If the answer is "Yes", please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.
NONE

If any of the shares of stock are pledged or hypothecated in any way, give details.

15. Have you ever been adjudged a bankrupt? **NO** If yes, provide details _____

16. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity? If yes, please indicate and give details. When responding to questions (b) and (c) affiant should also include any events within twelve (12) months after his or her departure from the entity.

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or Governmental-licensing agency? **NO**

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)? **NO**

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action? **NO**

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this _____ day of _____ 20 at _____ I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

[redacted]

(Signature of Affiant) Date

State of Washington County of King

The foregoing instrument was acknowledged before me this 25th day of Oct., 2006 By Lloyd R. Musselman and:

☒ who is personally known to me, or

☐ who produced the following identification: _____

[SEAL] HELEN M. BROWN COMMISSION EXPIRES NOTARY PUBLIC 4-28-07 STATE OF WASHINGTON

Helen M. Brown
Notary Public

Helen M. Brown
Printed Notary Name

4/28/07
My Commission Expires

Applicant Name **Lloyd Richard Musselman, Jr.**

NAIC No. _____
FEIN: _____

BIOGRAPHICAL AFFIDAVIT
Supplemental Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority.

Full Name, Address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

_____

_____

_____

1. a. Affiant's Full Name (Initials Not Acceptable). **Lloyd Richard Musselman, Jr.**

   b. Maiden Name (if applicable) _____

2. Affiant's Social Security Number [redacted]

3. Government Identification Number if not a U.S. Citizen **NONE**

4. Foreign Student ID# (if applicable) **N/A**

5. Date of Birth: (MM/DD/YY) [redacted] Place of Birth: City [redacted]
   State/Province [redacted] Country **USA**

6. Name of Affiant's Spouse (if applicable) [redacted]

7. List your residences for the last ten (10) years starting with your current address, giving:

Beginning/Ending Dates (MM/YY)	Address	City	State/ Province	Country	Postal Code
08/99 – present	[redacted]				
05/95 – 08/99					

Applicant Name **Lloyd Richard Musselman, Jr.**

NAIC No. _____
FEIN: _____

Dated and signed this _____ day of _____, 20 at _____ I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

[redacted]

(Signature of Affiant) Date

State of Washington County of King

The foregoing instrument was acknowledged before me this 25th day of Oct., 20 06 By Lloyd R. Musselman and:

☒ who is personally known to me, or

☐ who produced the following identification: _____

[SEAL] HELEN M. BROWN COMMISSION EXPIRES NOTARY PUBLIC 4-28-07 STATE OF WASHINGTON

Helen M. Brown
Notary Public

Helen M. Brown
Printed Notary Name

4/28/07
My Commission Expires

Applicant Name **Lloyd Richard Musselman, Jr.** NAIC No. _____
FEIN: _____

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS(*All states except California, Minnesota and Oklahoma)*

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of _____**[*insert* company name]**("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both)("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency ("CRA") that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact _____**[*insert* company's designated person, position, or department, address and phone]**.

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act."

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) twelve (12) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

_____ (Printed Full Name and Residence Address)

[redacted]

_____ (Signature) _____ (Date)

State of Washington County of King

The foregoing instrument was acknowledged before me this 25th day of Oct. 2006 By Lloyd R. Musselman and

☒ who is personally known to me, or

☐ who produced the following identification: _____

[SEAL] HELEN M. BROWN COMMISSION EXPIRES NOTARY PUBLIC 4-28-07 STATE OF WASHINGTON

Helen M. Brown
Notary Public

Helen M. Brown
Printed Notary Name

4/28/07
My Commission Expires

Applicant Name Mariella Cummings

NAIC No. _____
FEIN: _____

BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority.

(Print or Type)

Full Name, Address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names). _____

Puget Sound Health Partners, Inc., 708 Broadway, Suite 400, Tacoma WA 98402, (253) 779-8830

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. a. Affiant's Full Name (Initials Not Acceptable). **Mariella Cummings** NAME - NO MATCH
   Maiden Name (if applicable). **Mariella Harris**
2. a. Have you ever had your name changed? **Yes** If yes, give the reason for the change and provide the full name(s).
   December 1968: marriage. Mariella Harris assumed married name of Mariella Larter
   September 1900: marriage. Mariella Larter assumed married name of Mariella Cummings

   b. Other names used at any time (including aliases).

   Nicknames: Mary Larter, Mary Cummings, Mary H. Larter, Mary H. Cummings, Mariella H. Cummings

3. a. Are you a citizen of the United States? **Yes**

   b. Are you a citizen of any other country, if so, what country? **No**

4. Affiant's Occupation or Profession. **Management Consultant**
5. Affiant's business address. **Results Incorporated, 4020 Green Cove Street NW, Olympia WA 98502 (mailing address: PO Box 12233, Olympia, WA 98508)**

   Business telephone. **360.866.7780 or cell 360.701.1029**

original

Applicant Name _____ NAIC No. _____
FEIN: _____

6. Education and Training:

College/ University	City/ State	Dates Attended (MM/YY)	Degree Obtained
College of Notre Dame	**Belmont, CA**	**09/64 to 06/65**	**none**
Schiller College*	**Kleiningersheim, Germany**	**06/65 to 08/65**	**none**
University of Washington	**Seattle, WA**	**09/65 to 06/68**	**BS (nursing)**

Graduate Studies: College/ University	City/ State	Dates Attended (MM/YY)	Degree Obtained
University of Arizona	**Tucson AZ**	**09/73 to 06/75**	**MS**

Other Training: Name	City/ State	Dates Attended (MM/YY)	Degree/Certification Obtained
None			

(Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number in the space provided in the Biographical Affidavit Supplemental Information.) ***Campus at Kleiningersheim no longer operated. Main Schiller College Campus current address: 453 Edgewater Drive, Dunedin, FL 34698-7532. Phone number: 727.736.5082. Attended summer language institute as "Mariella Harris". At the time there was no foreign student ID number that I am aware of.**

7. List of memberships in professional societies and associations. **None**

Name of Society/Association	Contact Name	Address of Society/Association	Telephone Number of Society/Association

8. Present or proposed position with the applicant entity. **proposed Director**

List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years.

Beginning/Ending
Dates (MM/YY) **01/91- current** Employers' Name **Results Incorporated**
Address **PO Box 12233** City **Olympia** State/Province **WA**
Country **US** Postal Code **98508** Phone **360.866.7780** Offices/Positions Held **President 1993-current; Sr. Consultant , 1991-1993**
Supervisor / Contact : **Mariella Cummings/self. I am a self employed management consultant through "S" corporation**

Beginning/Ending
Dates (MM/YY) **03/01- current** Employers' Name **Physicians of Southwest Washington, LLC**
Address **2111 Harrison Ave NW** City **Olympia** State/Province **WA**
Country **US** Postal Code **98502** Phone **360.943.4337, ext 2** Offices/Positions Held **CEO through management services agreement with Results Incorporated**
Supervisor / Contact **Dr. Gary Goin, President 360.754-6460**

Applicant Name _____ NAIC No. _____
FEIN: _____

Beginning/Ending
Dates (MM/YY)**09/93-08/98** _____ Employers'Name **Washington State Department of Health**
Address **101 Israel Road SE** City **Tumwater** State/Province **WA**
Country **US** Postal Code **98501** Phone **360.236.4501** Offices/Positions Held **Director, Office of Infectious Disease and Reproductive Health**
Supervisor / Contact **Dr. Maxine Hayes 360.236.4108**

Beginning/Ending
Dates (MM/YY)**10/87- 09/92** Employers'Name **HealthTrust, Inc. (company no longer exists)**
Address **c/o HCA Inc, One Park Plaza** City **Nashville** State/Province **TN**
Country **US** Postal Code **37203** Phone **615.344.9551** Offices/Positions Held **CEO/Administrator, Capital Medical Center, Olympia, WA, and Administrator at Large**
Supervisor / Contact **W. Hudson Connery and Kent Wallace**

Beginning/Ending
Dates (MM/YY)**06/86 - 09-87** Employers' Name **Republic Health (company no longer exists)**
Address **Unknown** City **Dallas** State/Province **Texas**
Country **US** Postal Code **Unknown** Phone **unknown** Offices/Positions Held **Associate Administrator, Chief Operating Officer, North Miami Medical Center, North Miami, FL**
Supervisor / Contact **Dave VandeWater**

Beginning/Ending
Dates (MM/YY)**Several years in mid to late 1990's.** Name **Washington State Health Insurance Pool (WSHIP)**
Address **PO Box 329** City **Bow** State/Province **WA**
Country **US** Postal Code **98232-0329** Phone **360.766.0336** Offices/Positions Held **Consumer Rep to Board Appointed by former Insurance Commissioner Deborah Senn**
Supervisor / Contact **N/A**

10. a. Have you ever been in a position which required a fidelity bond? **no** If any claims were made on the bond, give details. **N/A**
    b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked? If yes, give details. **no**
11. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license (s) issued. Attach additional pages if the space provided is insufficient.

Organization/Issuer of License **Washington State Department of Health** Address **Health Professions Quality Assurance, PO Box 47865** City **Olympia** State/Province **WA** Country **US** Postal Code **98504-7865**

License Type **Registered Nurse** License # **RN 000042367** Date Issued (MM/YY) **09/68**

Date Expired (MM/YY) **N/A -current** Reason for Termination **N/A**

Non-insurance Regulatory Phone Number (if known) **360.236.4700**

Organization /Issuer of License **Florida Department of Health** Address **4052 Bald Cypress Way**
City **Tallahassee** State/Province **FL** Country **US** Postal Code **32399-0329**

License Type **Registered Nurse** License # **unknown** Date Issued (MM/YY) **??/86**

Date Expired (MM/YY) **??/87** Reason for Termination **Relocated to WA State**
Note: Have previously held RN licenses in Arizona, Montana, Indiana and Wisconsin from 1970-1986 when working in those states. All licenses were allowed to lapse upon relocation.

Non-insurance Regulatory Phone Number (if known) **Not Known**

Applicant Name _____ NAIC No. _____
FEIN: _____

12. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:

    a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency? **No**

    b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action? **No**

    c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action? **No**

    d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses? **No**

    e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses? **No**

    f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses? **No**

    g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking? **No**

    h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute? **Yes.**

    i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government? **No**

    j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity? **No**

    If the response to any question above is answered "Yes", please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

    12 (h) I was a member of an appointed ESOP Committee for HealthTrust, Inc. When HealthTrust was reorganized and sold, there was a dispute among and between various classes of HealthTrust employee owners as to how proceeds of their ownership interests were to be allocated among the classes of employees. As a member of the ESOP Committee, I was a named party to the litigation. The matter was settled out of court and there were no findings of any fault or misconduct by the ESOP Committee or any of the named Committee members. As a member of the ESOP Committee, I was indemnified and represented by Counsel appointed by HealthTrust. The matter was fully and finally resolved in approximately 1997. I did not retain any records and can not recall the exact dates. I did not retain any of the legal files and cannot provide a copy of any of the filings. Information about this matter may be on file with the legal department of Hospital Corporation of America, One Park Plaza, Nashville, TN 37203, which company acquired HealthTrust when it was sold.

13. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. **None**

Applicant Name _____ NAIC No. _____
FEIN: _____

If any of the stock is pledged or hypothecated in any way, give details. **N/A**

14. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified. If the answer is "Yes", please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities. **No**

    If any of the shares of stock are pledged or hypothecated in any way, give details. **N/A**

15. Have you ever been adjudged a bankrupt? **No** If yes, provide details **N/A**

16. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity? If yes, please indicate and give details. When responding to questions (b) and (c) affiant should also include any events within twelve (12) months after his or her departure from the entity.

    a. Been refused a permit, license, or certificate of authority by any regulatory authority, or Governmental-licensing agency? **No**

    b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)? **No**

    c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action? **No**

    Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 27th day of October 2006 at Olympia I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the [redacted]

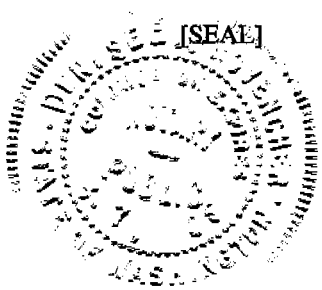
_____ 10-27-06
(Signature of Affiant) Date

State of Wa County of Thurston

The foregoing instrument was acknowledged before me this 27th day of Oct, 2006 By Marilla Cummings, and:

☑ who is personally known to me, or

☐ who produced the following identification: _____



Denise E. Frederick
Notary Public
Denise E. Frederick
Printed Notary Name
3-7-09
My Commission Expires

Applicant Name _____ NAIC No. _____
FEIN: _____

BIOGRAPHICAL AFFIDAVIT
Supplemental Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority.

Full Name, Address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Puget Sound Health Partners, Inc.
708 Broadway, Suite 400
Tacoma, WA 98402
(253) 779-8830

1. a. Affiant's Full Name (Initials Not Acceptable). **Mariella Cummings**

   b. Maiden Name (if applicable) **Mariella Harris**

2. Affiant's Social Security Number [redacted]

3. Government Identification Number if not a U.S. Citizen **N/A**

4. Foreign Student ID# (if applicable) **N/A**

5. Date of Birth: (MM/DD/YY) [redacted] Place of Birth: City [redacted]
   State/Province **WA** Country **US**

6. Name of Affiant's Spouse (if applicable) **N/A**

7. List your residences for the last ten (10) years starting with your current address, giving:

Beginning/Ending Dates (MM/YY)	Address	City	State/ Province	Country	Postal Code
04/03 to current	[redacted]				
11/00 to 04/03					
1990-09/2000					

Applicant Name _____ NAIC No. _____

FEIN: _____

Dated and signed this 27th day of October, 2006 at **Olympia, WA** I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

[redacted]

(Signature of Affiant)

10-27-06

Date

State of Wa County of Thurston

The foregoing instrument was acknowledged before me this 27th day of Oct., 20 06 By Marietta Cummings, and:

☑ who is personally known to me, or

☐ who produced the following identification: _____

[SEAL]

Denise E. Prohenchen

Notary Public

Denise E. Prohenchen

Printed Notary Name

3-7-09

My Commission Expires

Applicant Name _____ NAIC No. _____
FEIN: _____

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS*(All states except California, Minnesota and Oklahoma)*

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of **Puget Sound Health Partners, Inc.**]("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both)("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency ("CRA") that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact CEO, Puget Sound Health Partners, Inc., 708 Broadway, Suite 400, Tacoma, WA 98402, (253) 779-8830.

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act."

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) twelve (12) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

Mariella Cummings, [redacted]

_____ 10-27-06
(Signature) (Date)

State of Wa County of Thurston

The foregoing instrument was acknowledged before me this 27 day of Oct 20 06 By Mariella Cummings, and

☑ who is personally known to me, or

☐ who produced the following identification: _____

[SEAL]

Denise E. Prosenchak
Notary Public
Denise E. Prosenchak
Printed Notary Name
3-7-09
My Commission Expires

Applicant Name Patricia C. Briggs

NAIC No.
FEIN:

BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority.

(Print or Type)

Full Name, Address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names). Puget Sound Health Partners, Inc., 708 Broadway #400, Tacoma, WA 98402

(253) 779-8830

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. a. Affiant's Full Name (Initials Not Acceptable). Patricia Cecilia Briggs NAIC -

   b. Maiden Name (if applicable). Patricia Cecilia Sparks DO MATCH

2. a. Have you ever had your name changed? Yes ___ If yes, give the reason for the change and provide the full name(s).
   Marriage

   Patricia Cecilia Briggs

   b. Other names used at any time (including aliases).

   None

3. a. Are you a citizen of the United States? Yes ✓

   b. Are you a citizen of any other country, if so, what country? No

4. Affiant's Occupation or Profession. Chief Executive Officer, Northwest Physicians Network

5. Affiant's business address. 708 Broadway #400, Tacoma, WA 98402

   Business telephone. (253) 722-0311

Applicant Name Patricia C. Briggs

NAIC No. _____
FEIN: _____

6. Education and Training:

College/ University	City/ State	Dates Attended (MM/YY)	Degree Obtained
Oregon State University	Corvallis, Oregon	09/64 – 06/67	BA
Case Western Reserve University	Cleveland, Ohio	06/65 – 08/65	None
The College of William and Mary	Williamsburg, Virginia	08/67 – 12/67	None

Graduate Studies:	College/ University	City/ State	Dates Attended (MM/YY)	Degree Obtained
None				

Other Training: Name	City/ State	Dates Attended (MM/YY)	Degree/Certification Obtained
None			

(Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number in the space provided in the Biographical Affidavit Supplemental Information.)

7. List of memberships in professional societies and associations.

Name of Society/Association	Contact Name	Address of Society/Association	Telephone Number of Society/Association
American Medical Group Association (AMGA)	Ryan O'Connor	1422 Duke Street Alexandria, VA 22314	(703) 838-0033
Pierce Metro American Heart Association Board	Candis Jordan	708 Broadway #330 Tacoma, WA 98402	(253) 272-7854

8. Present or proposed position with the applicant entity. Board Member

9. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years.

Beginning/Ending Dates (MM/YY)01/98 ____ - present ___ Employers'Name Northwest Physicians Network

Address 708 Broadway #400 _____ City Tacoma _____ State/Province WA _____

Country USA _____ Postal Code 98402 _____ Phone (253) 627-4638 Offices/Positions Held Chief Operating Officer and Chief Executive Officer _____

Supervisor / Contact ____ Joseph Clabots, MD

Beginning/Ending Dates (MM/YY)05/95- 01/98 _____ Employers' Name Unified Physicians of Washington (no longer in business) ____

Address 33301 9th Ave S #200 _____ City Federal Way _____ State/Province WA _____

Country USA _____ Postal Code 98003 _____ Phone N/A _____ Offices/Positions Held Associate Director of Networks and Contracts _

Supervisor / Contact Theresa Dodd

Applicant Name Patricia C. Briggs

NAIC No. _____
FEIN: _____

Beginning/Ending Dates (MM/YY) 08/90 - 05/95 Employers' Name Franciscan Health Services Northwest

Address 1717 So J St City Tacoma State/Province WA

Country USA Postal Code 98405 Phone (253) 591-6622 Offices/Positions Held Director, Managed Care

Supervisor / Contact Sandy Habowski; Laure Nichols

Beginning/Ending Dates (MM/YY) 12/86 - 8/90 Employers' Name Sisters of Providence Health Plans (no longer in business)

Address N/A City Seattle State/Province WA

Country USA Postal Code N/A Phone N/A Offices/Positions Held Group Services Manager

Supervisor / Contact Eve Stern

10. a. Have you ever been in a position which required a fidelity bond? No ✓ If any claims were made on the bond, give details. _____

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked? If yes, give details. No ✓

11. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license (s) issued. Attach additional pages if the space provided is insufficient.

N/A

Organization/Issuer of License _____ Address _____

City _____ State/Province _____ Country _____ Postal Code _____

License Type _____ License # _____ Date Issued (MM/YY) _____

Date Expired (MM/YY) _____ Reason for Termination _____

Non-insurance Regulatory Phone Number (if known _____

Organization /Issuer of License _____ Address _____

City _____ State/Province _____ Country _____ Postal Code _____

License Type _____ License # _____ Date Issued (MM/YY) _____

Date Expired (MM/YY) _____ Reason for Termination _____

Non-insurance Regulatory Phone Number (if known) _____

Applicant Name Patricia C. Briggs

NAIC No. _____
FEIN: _____

12. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:

a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?
No

b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?
No

c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action? No

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses? No

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?
No

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses? No

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking? No

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute? No

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government? No

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?
No

If the response to any question above is answered "Yes", please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

13. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. N/A

Applicant Name Patricia C. Briggs

NAIC No. _____
FEIN: _____

If any of the stock is pledged or hypothecated in any way, give details. N/A

14. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified. If the answer is "Yes", please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.
No

If any of the shares of stock are pledged or hypothecated in any way, give details.
N/A

15. Have you ever been adjudged a bankrupt? No _____ If yes, provide details _____

16. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity? If yes, please indicate and give details. When responding to questions (b) and (c) affiant should also include any events within twelve (12) months after his or her departure from the entity.

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or Governmental-licensing agency? No

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?
No

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action? No

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 24th day of Oct. 2006 at Tacoma, Washington I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the

[redacted]

10/24/06
Date

State of Washington County of Pierce

The foregoing instrument was acknowledged before me this 24th day of October 2006 By Patricia C. Briggs, and:

☑ who is personally known to me, or

☐ who produced the following identification: _____

[SEAL]

JEAN M. GAMBRIELLE
COMMISSION EXPIRES
NOTARY
PUBLIC
9-29-08
STATE OF WASHINGTON

Jean M. Gambrielle
Notary Public
JEAN M. GAMBRIELLE
Printed Notary Name
9-29-08
My Commission Expires

Applicant Name Patricia C. Briggs

NAIC No.
FEIN:

BIOGRAPHICAL AFFIDAVIT
Supplemental Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority.

Full Name, Address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Puget South Health Partners, Inc., 708 Broadway #400, Tacoma, WA 98402 (253) 779-8830

1. a. Affiant's Full Name (Initials Not Acceptable). Patricia Cecilia Briggs

   b. Maiden Name (if applicable) Patricia Cecilia Sparks

2. Affiant's Social Security Number [redacted]

3. Government Identification Number if not a U.S. Citizen N/A

4. Foreign Student ID# (if applicable)

5. Date of Birth: (MM/DD/YY) [redacted] Place of Birth: City [redacted]
   State/Province Washington Country USA

6. Name of Affiant's Spouse (if applicable) [redacted]

7. List your residences for the last ten (10) years starting with your current address, giving:

Beginning/Ending Dates (MM/YY)	Address	City	State/ Province	Country	Postal Code
10/03 – Current	[redacted]				
09/86 – 09/03					

Applicant Name Patricia C. Briggs

NAIC No. _____
FEIN: _____

Dated and signed this 27th day of October, 2006 at Tacoma, Washington I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

[redacted]

10/24/06
Date

State of Washington County of Pierce

The foregoing instrument was acknowledged before me this 24th day of October, 2006 By Patricia C. Briggs, and:

☑ who is personally known to me, or

☐ who produced the following identification: _____

[SEAL]

JEAN M. GAMBRELLE
COMMISSION EXPIRES
NOTARY
PUBLIC
9-29-08
STATE OF WASHINGTON

Jean M. Gambrelle
Notary Public

JEAN M. GAMBRELLE
Printed Notary Name

9-29-08
My Commission Expires

Applicant Name Patricia C. Briggs

NAIC No. _____
FEIN: _____

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS*(All states except California, Minnesota and Oklahoma)*

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of Puget Sound Health Partners ("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both)("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency ("CRA") that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact _____[*insert* **company's designated person, position, or department, address and phone**].

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act."

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) twelve (12) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

[redacted]
(Printed Full Name and Residence Address)

[redacted]
(Signature)

10/24/06
(Date)

State of Washington County of Pierce

The foregoing instrument was acknowledged before me this 24th day of October 2006 By Patricia C. Briggs, and

☑ who is personally known to me, or

☐ who produced the following identification: _____

[SEAL]

JEAN M. GAMBRIELLE
COMMISSION EXPIRES
NOTARY
PUBLIC
9-29-08
STATE OF WASHINGTON

Jean M Gambrielle
Notary Public

JEAN M. GAMBRIELLE
Printed Notary Name

9-29-08
My Commission Expires

Marshall McGinnis

From: Howard Thomas [HTConsulting@comcast.net]
Sent: Friday, December 22, 2006 2:15 PM
To: Marshall McGinnis
Subject: Pat Briggs and Karen Lee

Marshall;

Here is another letter to help clear up the incidents that came up on the background checks for Pat Briggs and Karen Lee.

Pat Briggs was in fact Patricia Sparks many years ago. She was married and legally changed her name in 1967. Hopefully that clears that up for you.

Karen Lee was in fact Karen Baker. She did tell me that there was a lawsuit involving a motor vehicle accident and that her former husband was the driver and she was a named defendant. She indicated that this matter was taken over by their insurance company and the matter was resolved by them. This one should be closed.

She was married to her current husband and changed her name form Baker to Lee in July of 2000. Hopefully that helps to clear up the second lawsuit that you had mentioned which I presume was more recent than that. If you need additional info on any of this please let me know.

Sincerely,
Howard Thomas

Thomas & Associates Consulting, L.L.C.
425/888-4399
HTConsulting@comcast.net

Applicant Name Sarah M. Owens

NAIC No.
FEIN:

BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority.

(Print or Type)

Full Name, Address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Puget Sound Health Partners
7502 Lakewood Drive W, Suite A
Lakewood, WA 98499

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. a. Affiant's Full Name (Initials Not Acceptable). Sarah Matt Owens

   b. Maiden Name (if applicable).

2. a. Have you ever had your name changed? ✓ If yes, give the reason for the change and provide the full name(s).

   Sarah Owens Plovanich marriage / divorce

   b. Other names used at any time (including aliases).

3. a. Are you a citizen of the United States? yes

   b. Are you a citizen of any other country, if so, what country?

4. Affiant's Occupation or Profession. healthcare administration

5. Affiant's business address. 7502 Lakewood Drive W, Suite A. Lakewood WA 98499

   Business telephone 253-284-3939

Applicant Name Sarah M. Owens

NAIC No. _____
FEIN: _____

6. Education and Training:

College/ University	City/ State	Dates Attended (MM/YY)	Degree Obtained
State University of New York @ Albany	Albany, NY	08/77 - 05/81	BA

Graduate Studies:	College/ University	City/ State	Dates Attended (MM/YY)	Degree Obtained

Other Training: Name	City/ State	Dates Attended (MM/YY)	Degree/Certification Obtained
Rensselaer Polytechnic Institute	Troy, NY	1981	Management Certificate AMP Exec.

(Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number in the space provided in the Biographical Affidavit Supplemental Information.)

7. List of memberships in professional societies and associations.

Name of Society/Association	Contact Name	Address of Society/Association	Telephone Number of Society/Association

8. Present or proposed position with the applicant entity. Chief Operating Officer

9. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years.

Beginning/Ending Dates (MM/YY) 09/06 - 02/08 Employer's Name Royal Health Care
Address 521 5th Avenue 3rd Floor City New York State/Province NY
Country USA Postal Code 10175 Phone 212-808-4375 Offices/Positions Held Director
Supervisor / Contact Cathy Weigle

Beginning/Ending Dates (MM/YY) 07/00 - 09/06 Employer's Name Continuum Health's MSO
Address 555 West 57th St. 3rd Floor City New York State/Province NY
Country USA Postal Code 10019 Phone 212-523-4882 Offices/Positions Held Executive Director
Supervisor / Contact Ruth Levin

Applicant Name Sarah M. Owens NAIC No. _____ FEIN: _____

Beginning/Ending Dates (MM/YY) 05/92 - 07/99 Employer's Name Bronx Lebanon Hospital Center

Address Grand Concourse City Bronx State/Province NY

Country USA Postal Code 10456 Phone 718-590-1800 Offices/Positions Held Assistant Vice President Executive Director

Supervisor / Contact Pauline Marks

Beginning/Ending Dates (MM/YY) 7/94 - 5/97 Employer's Name Harvard Pilgrim Health Care

Address 1600 Crown Colony Dr. ~~Harvard Square~~ City Quincy ~~Brookline~~ State/Province MA

Country USA Postal Code 02169 Phone 1617-509-1000 Offices/Positions Held Program Administrator

Supervisor / Contact Dr. Marvin Wool

10. a. Have you ever been in a position which required a fidelity bond? no If any claims were made on the bond, give details. _____

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked? If yes, give details. no

11. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license (s) issued. Attach additional pages if the space provided is insufficient.

Organization/Issuer of License _____ Address _____

City _____ State/Province _____ Country _____ Postal Code _____

License Type _____ License # _____ Date Issued (MM/YY) _____

Date Expired (MM/YY) _____ Reason for Termination _____

Non-insurance Regulatory Phone Number (if known _____

Organization /Issuer of License _____ Address _____

City _____ State/Province _____ Country _____ Postal Code _____

License Type _____ License # _____ Date Issued (MM/YY) _____

Date Expired (MM/YY) _____ Reason for Termination _____

Non-insurance Regulatory Phone Number (if known) _____

Applicant Name Sarah M. Owens

NAIC No. _____
FEIN: _____

12. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:

a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?
no

b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?
no

c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action? no

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses? no

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?
no

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses? no

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking? no

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute? no

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government? no

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?
no

If the response to any question above is answered "Yes", please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

13. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.

Applicant Name Sarah M. Owens

NAIC No. _____
FEIN: _____

If any of the stock is pledged or hypothecated in any way, give details. _____

14. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified. If the answer is "Yes", please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

no

If any of the shares of stock are pledged or hypothecated in any way, give details.

15. Have you ever been adjudged a bankrupt? no If yes, provide details _____

16. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity? If yes, please indicate and give details. When responding to questions (b) and (c) affiant should also include any events within twelve (12) months after his or her departure from the entity.

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or Governmental-licensing agency? no

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to *any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership,* conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

no

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action? no

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this ninth day of Sept 2008 at eleven twenty-three am. I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the

[redacted]

(Signature of Affiant) 9/9/08 Date

State of Washington County of King Reice (3rd)

The foregoing instrument was acknowledged before me this 9 day of September 08 By Sarah Owens, and:

X who is personally known to me, or

☐ who produced the following identification: _____

[SEAL]

Faith E McNab
Notary Public

Faith E McNab
Printed Notary Name

05/27/2012
My Commission Expires

©National Association of Insurance Commissioners

Applicant Name Sarah M. Owens

NAIC No.
FEIN

BIOGRAPHICAL AFFIDAVIT
Supplemental Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority.

Full Name, Address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Puget Sound Health Partners
7502 Lakewood Drive W. Suite A
Lakewood, WA 98499

1. a. Affiant's Full Name (Initials Not Acceptable). Sarah Mae Owens

   b. Maiden Name (if applicable) [redacted]

2. Affiant's Social Security Number [redacted]

3. Government Identification Number [redacted] U.S. Citizen

4. Foreign Student ID# (if applicable) [redacted]

5. Date of Birth: (MM/DD/YY) [redacted] Place of Birth: City [redacted]
   State/Province [redacted] Country [redacted]

6. Name of Affiant's Spouse (if applicable) [redacted]

7. List your residences for the last ten (10) years starting with your current address, giving:

Beginning/Ending Dates (MM/YY)	Address	City	State/ Province	Country	Postal Code
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Applicant Name Sarah M. Owens

NAIC No. _____

FEIN: _____

Dated and signed this 9th day of September, 2008 at eleven twenty-eight a.m. I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

[redacted]

(Signature of Affiant)

9/9/08

Date

State of Washington County of Pierce

The foregoing instrument was acknowledged before me this 9 day of September, 20 08 By Sarah Owens, and:

☒ who is personally known to me, or

☐ who produced the following identification: _____

[SEAL]

Faith E McNab

Notary Public

Faith E McNab

Printed Notary Name

02/27/2012

My Commission Expires

FAITH E. MCNAB
NOTARY PUBLIC
2-27-12
STATE OF WASHINGTON

Applicant Name Sarah M. Owens

NAIC No. _____
FEIN: _____

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS*(All states except California, Minnesota and Oklahoma)*

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of PSHP [*insert* **company name**]("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both)("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency ("CRA") that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact _____ [*insert* **company's designated person, position, or department, address and phone**].

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act."

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) twelve (12) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

[redacted]

[redacted] 9/9/08

(Signature) (Date)

State of Washington County of ~~King~~ Pierce (Tm)

The foregoing instrument was acknowledged before me this 9 day of September 20 08 By Sarah Owens, and

☒ who is personally known to me, or

☐ who produced the following identification: _____

[SEAL]

Faith E McNab
Notary Public

Faith E McNab
Printed Notary Name

02/27/2012
My Commission Expires

©National Association of Insurance Commissioners

Sarah M. Owens

[redacted]

Profile: Accomplished executive with over twenty years of health care administration experience at some of the largest health care delivery systems and health plans in the country. Diligent, goal-oriented, results focused leader with the full range of leadership experience in managed care insurance and health care operations.

Major Achievements

- Developed a Medicaid/Medicare Advantage Managed Long Term Care plan at Royal Health Care.
- Formed a management services organization (MSO) for Continuum, a major New York Hospital System, to manage a risk contract for HIP Health Plan at six sites in Manhattan. Expanded to include other hospital primary care sites. Developed budgets, hired operational staff for utilization management, customer service and claims oversight. Formulated strategy and negotiated capitated specialty and fee for service hospital and ancillary contracts.
- Developed managed care strategy for Bronx Lebanon Hospital, a complex hospital system including medical and psychiatric services, and a nursing home. Contracted with all major health plans on behalf of the hospital and voluntary and staff physicians. Revitalized a physician oversight body to ensure a common understanding of managed care principles and to determine the strategy for contracting and delivery system management.
- Designed and implemented an innovative program in Massachusetts with Harvard Pilgrim Health Care (HPHC) to align the financial incentives of independent physicians, organized into risk bearing groups, with quality measures, including selection of measures, reporting and formulation of improvement plans.
- Directed the contracting and provider relations for Blue Cross and Blue Shield of Massachusetts on all product lines for the hospitals and physicians in the greater Boston region.

Professional Experience

Independent Consulting, New York, New York 10128 — 2008 - present

- Evaluating opportunities for health plans to identify physician diagnostic under-coding that will affect Hierarchical Condition Categories (HCCs) and Clinical Risk Groups (CRGs). Providing analysis to hospitals and medical groups on risk assessment of contracts and contracted services.

Royal Health Care, 521 5th Avenue, New York, NY 10175 — 2006 - 2008

Director of Client Implementation and Support

- Joined the management team of a company that provides management services organization services (MSO) to an expanding number of health plans serving Medicare, Medicaid, Special Needs Plans and commercial customers. Wrote policies and procedures for client service and support.
- Developed a Managed Long Term Care plan for one client writing the applications to the State of New York and CMS. Obtained one of the last Special Needs Plan designations. With medical leadership, designed strategy of operation and wrote corresponding policies and process guidelines.

Continuum Health's MSO, 555 West 57th Street, New York, NY 10019 **2000 - 2006**

Executive Director

- Formed a management services organization (MSO) to manage a 5 year, $400 Million contract between HIP of New York and Continuum Health Partners, a consortium of hospitals, including Beth Israel Medical Center and St. Lukes-Roosevelt Hospital.
- Obtained a State Utilization Review (UR) Agency License under Article 49.
- Developed operational and staffing models and the budget to support.
- Recruited and coached clinical and non-clinical staff to perform UR and Quality Improvement, claims and customer service functions.
- Provided oversight for the IPA of all health plan operations, setting policies and procedures to achieve the goals of the IPA.
- Directed all contracting services for the IPA.

Independent Consulting, New York, NY **1999 – 2000**

- Assessed operations and implemented organizational changes for Columbia Cornell Care and other health systems. Evaluated and revised credentialing process, contracts and collateral materials such as manuals and marketing literature.

Bronx-Lebanon Hospital Center, Bronx, NY. **1997 – 1999**

Executive Director and Assistant Vice President of Managed Care.

- Developed managed care strategy, working with other senior administration and physician leadership. System included over 400 physicians, a 400 bed teaching hospital, 150 bed psychiatric hospital, an AIDS designated center and a dental IPA.
- Led team in contracting, health plan relations, provider relations, member services, marketing, credentialing and reporting.

Harvard Pilgrim Health Care, Brookline, MA **1994 - 1997**

Joint Venture Program Administrator

- Managed clinical, analytic and project management staff providing consultative services to health care providers grouped in joint ventures (risk bearing groups).
- Developed and implemented quality incentive bonus program. Designed standard process for provider support and report production, distribution and evaluation based on size of network, configuration, market penetration and market potential.
- Evaluated options for specialty joint ventures and implemented a new program for specialty management (radiology). Benefits of the program were improved accuracy, reliability and efficacy of imaging.

Blue Cross and Blue Shield of Massachusetts, Boston, MA 1991 – 1994

Regional Director Network Development and Management (1992 - 1994)

- Developed strategic plan to assess, analyze, design and implement quality improvement teams in the Boston region.
- Coached two regional teams of contracting and provider relations staff for all product lines, including indemnity, government programs and managed care.
- Developed collaborative relationships with administrators and medical directors at their hospitals, referral circles, delivering useful information to the local systems and assisting in the evaluation of medical care and financial performance.

Director of Product Management and Reporting for HMO Blue (1991 - 1992)

- Managed resources and professional staff in three areas:
  Product development and implementation e.g. point of service (POS) and low option;
  Research, member satisfaction and other studies to support organizational goals; and
  Reporting on a regional and plan-wide basis (report development on new IDX system).

Community Health Plan, Latham, NY 1985 - 1991

Planning Administrator/Regional Administrator/Marketing Manager (1986 - 1991)

- Senior management of central planning department. Developed Point of Services (POS).
- Managed operations and marketing for six county Central New York region (joint venture with The Mary Imogene Bassett Hospital). Contracted with physicians, hospitals and ancillary providers. Developed and implemented marketing plan.
- Region outperformed all targets and had the largest per member per month (PMPM) surplus of all regions in 1989.

Marketing Representative (1985 - 1986)

Capital District Physicians Health Plan, Albany, NY 1983 - 1985

Marketing Coordinator

Education

Rensselaer Polytechnic Institute, Troy, NY 1989
Management training for HMO executives.

State University of New York at Albany, Albany, NY 1981
Bachelor of Arts

Related Experience

Medical Group Management Association present
Member

American Psychiatric Association 1999

Faculty at National Meetings in New Orleans
Presented on managed care and risk management and led a panel discussion on the value of consultative services at the annual meeting held in New Orleans in October of 1999.

Health Insurance Association on America 1993 - 1994

Certified in Group Life and Health Insurance Levels 1 and 2

Group Health Association of America (GHAA), Washington, DC 1993
renamed American Association of Health Plans (AAHP)

Faculty at Network Development Conference
Presented paper on two case studies of network development for point of service.

NY State HMO Conference, Latham, NY and 1987 - 1991
Group Health Association of America, Washington, D.C.

Sales/Marketing Trainer
Facilitated Professional Selling Skills – A Need Satisfaction Selling Program

St. Peter's Hospice, Albany, NY 1982 - 1986

Hospice Volunteer

Applicant Name Zachary Smulski

NAIC No. _____
FEIN: _____

BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority.

(Print or Type)

Full Name, Address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names). _____

_____

_____

_____

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. a. Affiant's Full Name (Initials Not Acceptable). Zachary Augustus Smulski

   b. Maiden Name (if applicable). _____

2. a. Have you ever had your name changed? No If yes, give the reason for the change and provide the full name(s).

   _____

   _____

   _____

   b. Other names used at any time (including aliases).

   _____

   _____

3. a. Are you a citizen of the United States? YES

   b. Are you a citizen of any other country, if so, what country? No

4. Affiant's Occupation or Profession. Finance & Accounting

5. Affiant's business address. 400 Mercer St. Suite 410, Seattle, WA 98109

   Business telephone. 206.658.2950

Applicant Name Zachary Smalski

NAIC No. _____
FEIN: _____

6. Education and Training:

College/ University	City/ State	Dates Attended (MM/YY)	Degree Obtained
City University	Bellevue, WA	09/80 - 06/81	BA-Business Admin

Graduate Studies: College/ University	City/ State	Dates Attended (MM/YY)	Degree Obtained
University of Washington	Seattle, WA	09/00 - 03/03	M.B.A.

Other Training: Name	City/ State	Dates Attended (MM/YY)	Degree/Certification Obtained
LOMA	Seattle WA	01/86 to 12/87	FLMI

(Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number in the space provided in the Biographical Affidavit Supplemental Information.)

7. List of memberships in professional societies and associations.

Name of Society/Association	Contact Name	Address of Society/Association	Telephone Number of Society/Association
Washington Society of CPA	Jennifer Ayoub	902 140th Ave NE. Bellevue, WA 98005-3480	(425) 644-4800

8. Present or proposed position with the applicant entity. Chief Financial Officer

9. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years.

Beginning/Ending Dates (MM/YY) 11/01 - 10/08 Employer's Name Sea Mar Community Health Centers

Address 1040 S. Henderson City Seattle State/Province WA

Country USA Postal Code 98108 Phone (206) 763-5277 Offices/Positions Held C.F.O.

Supervisor / Contact Rogelio Riojas

Beginning/Ending Dates (MM/YY) 01/01 - 12/01 Employer's Name Independent Business Consultant

Address 3418 Phillip City Enumclaw State/Province WA

Country USA Postal Code 98022 Phone (425) 941-7870 Offices/Positions Held Consultant

Supervisor / Contact Self Employed 425-941-7870

Applicant Name Zachary Smulski NAIC No. _____ FEIN: _____

Beginning/Ending Dates (MM/YY) 01/99 - 01/01 Employer's Name Regence Blue Shield

Address 1800 9th Ave City Seattle State/Province WA

Country USA Postal Code 98101-1322 Phone (206) 464-3600 Offices/Positions Held MANAGER

Supervisor / Contact Rich Nelson Rich.Nelson@hotmail.com

Beginning/Ending Dates (MM/YY) 05/98 - 01/99 Employer's Name Robert Half International Management Resources Division

Address 601 Union St. City Seattle State/Province WA

Country USA Postal Code 98101 Phone 206 749-0960 Offices/Positions Held Consulting

Supervisor / Contact RHI Supervisor left firm - cannot locate

Worked for Regence / Rich Nelson during this consulting engagement

10. a. Have you ever been in a position which required a fidelity bond? Yes If any claims were made on the bond, give details. No

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked? If yes, give details. No

11. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license (s) issued. Attach additional pages if the space provided is insufficient.

Organization/Issuer of License Board of Accountancy Washington State Address 711 Capital Way South, Suite 400

City Olympia State/Province WA Country USA Postal Code 98501

License Type CPA License # [redacted] Date Issued (MM/YY) 03/89

Date Expired (MM/YY) Active Reason for Termination _____

Non-insurance Regulatory Phone Number (if known 360-753-2585

Organization /Issuer of License _____ Address _____

City _____ State/Province _____ Country _____ Postal Code _____

License Type _____ License # _____ Date Issued (MM/YY) _____

Date Expired (MM/YY) _____ Reason for Termination _____

Non-insurance Regulatory Phone Number (if known) _____

Applicant Name Zachary Smulski

NAIC No. _____
FEIN: _____

9. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years.

Beginning/Ending Dates (MM/YY) 03/92 - 01/98 Employer's Name Olympic Health Mgmt Systems

Address 2219 Rinland Dr City Bellingham State/Province WA

Country USA Postal Code 98227 Phone (888) 260-9660 Offices/Positions Held Vice President

Supervisor / Contact Dan Solberg → 954 290-6914

Beginning/Ending Dates (MM/YY) 7/91 - 3/92 Employer's Name Uniglobe Columbia Travel

Address 180 Palouse St. City Wenatchee State/Province WA

Country USA Postal Code 98801 Phone (425) 941-7870 Offices/Positions Held Managing Partner

Supervisor / Contact Self - Employed 425-941-2870

Applicant Name _____

NAIC No. _____
FEIN: _____

Beginning/Ending Dates (MM/YY) 1/86 - 6/91 Employer's Name Priarie States Life Insurance Co. *

Address 440 Mt. Rushmore Rd. City Rapid City State/Province SD

Country USA Postal Code 57701 Phone 800-333-2220 Offices/Positions Held Acctg Manager

Supervisor / Contact Dan Solberg 954-290-6914

Beginning/Ending Dates (MM/YY) _____ - _____ Employer's Name _____

Address _____ City _____ State/Province _____

Country _____ Postal Code _____ Phone _____ Offices/Positions Held _____

Supervisor / Contact _____

(# American Guaranty Life Ins. Co.)

* Priarie States Life Insurance Company
Home Office: Rapid City S.D.
Seattle Office: Last Known location
Kirkland, WA
800-626-0459
I worked for West Coast Subsidiaries that no longer Exist; They were merged into PSLIC; These include Omega National Ins. Co.; Purple Cross Ins. Co. and #

Applicant Name Zachary Smulski

NAIC No. _____
FEIN: _____

12. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:

a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency? No

b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action? No

c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action? No

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses? No

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses? No

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses? No

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking? No

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute? No

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government? No

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity? To the best of my knowledge, I am not aware of any liens or foreclosures

If the response to any question above is answered "Yes", please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

13. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.

None

Applicant Name _____ NAIC No. _____
FEIN: _____

If any of the stock is pledged or hypothecated in any way, give details. N/A

14. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified. If the answer is "Yes", please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

No

If any of the shares of stock are pledged or hypothecated in any way, give details.

15. Have you ever been adjudged a bankrupt? No If yes, provide details _____

16. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity? If yes, please indicate and give details. When responding to questions (b) and (c) affiant should also include any events within twelve (12) months after his or her departure from the entity.

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or Governmental-licensing agency? No

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)? No

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action? No

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 25th day of Sept 2008 at Seattle, WA I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

[redacted] 9/25/2008
(Signature of Affiant) Date

State of Washington County of King

The foregoing instrument was acknowledged before me this 25th day of September 2008 By me, and:

☒ who is personally known to me, or

☐ who produced the following identification: _____

DONNA M. PAINCHAUD
COMMISSION EXPIRES
NOTARY
PUBLIC
08-01-11
STATE OF WASHINGTON

Notary Public
Donna M. Painchaud
Printed Notary Name
08-01-11
My Commission Expires

Applicant Name Zachary Smulski

NAIC No. _____
FEIN: _____

BIOGRAPHICAL AFFIDAVIT
Supplemental Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority.

Full Name, Address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

_____

_____

_____

1. a. Affiant's Full Name (Initials Not Acceptable). Zachary Augustus Smulski

   b. Maiden Name (if applicable) _____

2. Affiant's Social Security Number [redacted]

3. Government Identification Number if not a U.S. Citizen _____

4. Foreign Student ID# (if applicable) _____

5. Date of Birth: (MM/DD/YY) [redacted] Place of Birth: City [redacted]
   State/Province [redacted] Country [redacted]

6. Name of Affiant's Spouse (if applicable) [redacted]

7. List your residences for the last ten (10) years starting with your current address, giving:

Beginning/Ending Dates (MM/YY)	Address	City	State/ Province	Country	Postal Code
[redacted]					

Applicant Name Zachary Smulski

NAIC No. _____

FEIN: _____

Dated and signed this 25 day of Sept, 2008 at Seattle, WA I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

[redacted]

(Signature of Affiant)

9/25/2008

Date

State of Washington County of King

The foregoing instrument was acknowledged before me this 25th day of September, 2008 By me, and:

☒ who is personally known to me, or

☐ who produced the following identification: _____

[SEAL]

DONNA M. PAINCHAUD
COMMISSION EXPIRES
NOTARY PUBLIC
08-01-11
STATE OF WASHINGTON

Notary Public

Donna M. Painchaud

Printed Notary Name

08-01-2011

My Commission Expires

Applicant Name Zachary Smulski

NAIC No. _____
FEIN: _____

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS(*All states except California, Minnesota and Oklahoma)*

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of _____ **[*insert* company name]**("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both)("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency ("CRA") that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact _____ **[*insert* company's designated person, position, or department, address and phone]**.

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act."

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) twelve (12) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

Zachary Augostos Smulski [redacted]
(Printed Full Name and Residence Address)

[redacted] 9/25/2008
(Signature) (Date)

State of Washington County of King

The foregoing instrument was acknowledged before me this 25th day of September 2008 By me, and

☒ who is personally known to me, or

☐ who produced the following identification: _____

DONNA M. PAINCHAUD
COMMISSION EXPIRES
NOTARY
PUBLIC
08-01-11
STATE OF WASHINGTON

Notary Public

Donna M. Painchaud
Printed Notary Name

08-01-2011
My Commission Expires

Zachary Smulski

[redacted]

Summary: Executive manager, MBA, CPA, and consultant with 15+ years of experience in:

- **Financial management:** Significantly improved profitability for organizations, operating divisions, and clients. Responsible for budgeting, forecasting, investments, and system conversions. Have led finance, accounting, operations and information system departments.
- **Project management:** Developed and implemented claims, accounting, and billing systems. Improved operational efficiencies, re-engineered systems, and merged operations.
- **Consulting:** Business plans, business strategies, revenue growth, mergers & acquisitions, cost and profitability analysis.
- **Contracting & Compliance:** System and technology applications, privacy and security, employee health and retirement plans, insurance, provider networks, managed care, and risk management.
- **Analysis & reporting:** Product pricing, financial modeling, decision support, variance analysis, cost accounting, and internal controls. Proficient with MS Access, MS Project and Excel.
- **Teambuilding:** Mentoring, coaching, training, and organizational development.

EXPERIENCE

SEA MAR COMMUNITY HEALTH CENTERS, Seattle WA 11/2001 to present

Chief Financial Officer

Sea Mar is a non-profit health and social service organization with three 501(c)3 and one for-profit subsidiary. Sea Mar operates Community Health Centers and a Skilled Nursing Facility with 34 locations throughout Washington. Sea Mar has annual revenue of over $90 million and provides 400,000 healthcare visits per year with over 175 providers and approximately 1,000 employees. Manage the accounting, billing, payroll, IT, purchasing and HR departments.

- Develop financial management team
- Work with operations & clinical staff to improve financial performance of 50+ departments
- Develop monthly management reports, financial metrics, and performance indicators
- Review annual audit and management letter with external auditors
- Report monthly financial results to CEO and Board of Directors
- Review annual 990 tax returns
- Facilitated financial discussions at board meeting and the Board's selection of auditors
- Completed several tax-exempt multi-million dollar bond financing
- Led project team in implementing new billing system
- Improved AR collections and cash flow by $15 million
- Implemented cash management program, lockbox processing, payment and denial tracking
- Negotiated contracts for new software applications
- Led HR system conversion & transfer of employee retirement plan to new administrator
- Ensure compliance with HIPAA, privacy and security regulations for Finance
- Advocacy to State Legislators to increase access to healthcare for children and uninsured
- Participated in a number of Sea Mar and community events throughout the year

INDEDENDENT BUSINESS CONSULTANT, Enumclaw, WA 2/2001 to 12/2001

Financial business advisory services and management research

Analyzed clients' financial data and implemented profitability improvement programs. Clients include healthcare providers, health plans, and an international healthcare organization. Assisted clients in recovering $2 million dollars in managed care contracts. Business commentary published in *The Bulletin*, King County Medical Society.

REGENCE BLUESHIELD, Seattle, WA 1998 to 1/2001

Senior Manager, Management Analysis & Reporting (1999 to 1/2001)

Reported directly to the President/CEO and was responsible for helping Regence achieve profitability through a number of initiatives.

- Led departmental team that identified $25 million in potential savings and helped improve Regence's financial performance.
- Identified $1.5 million of inappropriate medical claim payments.
- Designed financial reports, cost metric analysis, and management reports. Directed programming development team for data reporting system. Recommended financial improvement strategies.

Financial Consultant (1998 to 1999)

- Led team that improved Medicaid HO program from a $6 million loss to a $4 million gain
- Provided financial guidance & strategies for a 100,000 member group. Supported budgeting, health care planning, cost reductions, health care benefit cost analysis & negotiations.
- Helped negotiate Regence's Healthy Options Medicaid contracts with medical groups. Developed pricing models, financial contracts, and reinsurance agreements.
- Developed new risk-sharing reports and accounting system to help manage risk-sharing contracts for medical groups participating with Regence in Healthy Options & BHP

OLYMPIC HEALTH MANAGEMENT SYSTEMS, Bellingham, WA 1992 to 1998

Healthcare consulting and Management Company specializing in Medicare/Medicaid managed care plans with a secondary emphasis in commercial plans. Olympic has 600 healthcare clients in 27 states. Company grew from 20 employees in 1992 to 400 when purchased by Aon in 1998.

Vice President - Finance (1995 to 1998)

Health plan CFO responsible for profit & loss of a $10 million division. Reported to COO and managed claims administration, financial analysis, accounting, information systems, customer service, account management and business development. Led a staff of 30.

- Implemented new cash management system, banking relationships and investment program that generated $750,000 in additional annual revenue
- Led financial turnaround of two multi-million dollar divisions
- Led project team implementing relational database system, included designing database, selecting development tools, and developing applications. New system allowed company to handle 1000% growth with only a 50% increase in staffing. Developed new operational procedures and accounting policies in conjunction with new system efficiencies.

OLYMPIC HEALTH MANAGEMENT SYSTEMS, INC., Bellingham, WA (continued)

Vice President - Finance (1995 to 1998)

- Developed and implemented business plans that increased revenues up to 30% and improved profitability up to 50% over a 3-year period for various healthcare clients.
- Successfully negotiated insurance contracts that protected client over $25 million in catastrophic claims. Evaluated excess reinsurance risk. Negotiated technology-licensing agreements allowing efficient implementation of new automated computer systems.

Health Plan Controller (1993 to 1995)

- Led project team re-engineering systems and operations saving over $500,000 per year.
- Led three accounting system conversions.
- Coordinated and developed annual budget, five-year financial forecasts, and capital budgets.
- Completed valuations, due diligence, and accounting for mergers and acquisitions. Merged information systems and operations of acquisitions.
- Reduced administrative costs from $13 million to $5 million in 2 years
- Reviewed audit findings, internal control evaluations, management letters and responses.

Financial Analyst (1992)

- Communicated financial, marketing, & operating results & variances to boards & committees
- Designed and implemented cash management system, cost accounting system, and employee healthcare benefit & financial analysis systems. Developed IBNR reserving model.
- Assisted clients in developing medical networks, business pricing models, and analyzing/reducing cost.
- Developed and implemented product pricing plans and insurance reimbursement rates.

PRIARIE STATES LIFE INSURANCE COMPANY & SUBSIDIARIES 1986 to 1991

- Accounting Manager (1989 to 1991)
- Senior Accountant (1988 to 1989)
- Accountant (1986 to 1988)

EDUCATION

- MBA – University of Washington (GPA: 3.5)
- CPA - Washington State (Inactive)
- BS – Business Administration / Accounting, City University, Seattle WA

OTHER ACTIVITIES

2007-Current King County Medical Society Project Access - Finance Committee

2006-Current Washington Association of Community and Migrant Health Centers Finance Committee

2001-02 KBD Foundation, Board of Directors