

**CollabHealth Managed Solutions, Inc.**  
(Applicant's Parent Company)

Chairman of the Board: Dean Swindle  
State of Incorporation: Colorado

**Officers of CollabHealth Managed Solutions:**

CEO            Juan Serrano [Previously Submitted]  
Treasurer     Nick Barto  
Secretary     Linda DuPuis [Previously Submitted]

**Board Members:**

Juan Serrano, CEO [Previously Submitted]

Dean Swindle, Chairman of the Board [~~To Be Provided at a Later Date~~]

*ASL*

John DiCola

Cliff Deveny, MD

Michael Rowan

Robert Strickland

Mitch Melfi, JD



Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No.

FEIN

46-1222808

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).

CollabHealth Managed Solutions, Inc.
198 Inverness Drive West
Englewood, CO 80112
Ph: 720-874-1293

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). Nicholas Michael Barto
2. a. Are you a citizen of the United States? Yes
b. Are you a citizen of any other country, if so, what country? No
3. Affiant's Occupation or Profession. Catholic Health Initiatives - Managing director, CHI Ventures
4. Affiant's business address. 198 Inverness Drive West, Englewood, CO 80112
Business telephone. (303) 383-2787

5. Education and Training:

Table with 4 columns: College/ University, City/ State, Dates Attended (MM/YY), Degree Obtained. Row 1: Princeton University, Princeton, NJ, 09/90 - 06/94, BA, Economics

Table with 5 columns: Graduate Studies, College/ University, City/ State, Dates Attended (MM/YY), Degree Obtained. Row 1: Business Administration, Columbia Business School, New York, NY, 06/00, MBA

Table with 4 columns: 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.)

**Confidential**  
**Personal Information**

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No.

FEIN: 46-1222808

6. List of memberships in professional societies and associations.

<u>Name of Society/Association</u>	<u>Contact Name</u>	<u>Address of Society/Association</u>	<u>Telephone Number of Society/Association</u>
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7. Present or proposed position with the applicant entity. Treasurer

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) 06/12 – present Employer's Name Catholic Health Initiatives

Address 198 Inverness Drive West City Englewood State/Province CO

Country USA Postal Code 80112 Phone (303) 298-9100 Offices/Positions Held Managing Director

Supervisor / Contact Dean Swindle / Phone: (303) 383-2708

Beginning/Ending

Dates (MM/YY) 07/04 – 06/12 Employer's Name Novant Health

Address 108 Providence Road City Charlotte State/Province NC

Country USA Postal Code 28207 Phone (704) 384-7370 Offices/Positions Held Senior Vice President

Supervisor / Contact Fred Hargett / Phone: (704) 384-7370

Beginning/Ending

Dates (MM/YY) 2002 – 2004 Employer's Name McColl Partners

Address 100 North Tyron Street, 54<sup>th</sup> floor City Charlotte State/Province NC

Country USA Postal Code 28207 Phone (704) 333-0525 Offices/Positions Held Associate

Supervisor / Contact Dave Varhoff / Phone: (704) 333-0525

Beginning/Ending

Dates (MM/YY) 2000-2002 Employer's Name Lehman Brothers

Address 745 7<sup>th</sup> Avenue City New York State/Province NY

Country USA Postal Code 10019 Phone (212) 526-7000 Offices/Positions Held Associate

Supervisor / Contact Larry Marsh / Phone: (212) 526-7000

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Personal Information***

Beginning/Ending

Dates (YY) 1994 - 1999

Employer's Name The Wilkerson Group

Address 666 3<sup>rd</sup> Avenue

City New York

State/Province NY

Country USA

Postal Code 10023

Phone \_\_\_\_\_

Offices/Positions Held Associate

Supervisor / Contact Bob Easton

**Confidential  
Personal Information**

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No. \_\_\_\_\_  
FEIN 46-1222808

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

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

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

**Confidential**  
**Personal Information**

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No. \_\_\_\_\_

FEIN: 46-1222808

- 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. NO

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

\_\_\_\_\_  
\_\_\_\_\_

**Confidential  
Personal Information**

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No. \_\_\_\_\_  
FEIN \_\_\_\_\_

46-1222808

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.

- 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.

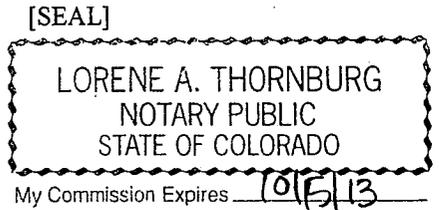
Dated and signed this 14<sup>th</sup> day of DECEMBER 2012 at 198 Inverness Drive West, Englewood, CO 80112, I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

[Signature]  
(Signature of Affiant)

State of Colorado County of Adair

The foregoing instrument was acknowledged before me this 14<sup>th</sup> day of Dec, 2012 By Nicholas Michael Barto and:

- who is personally known to me, or
- who produced the following identification: \_\_\_\_\_



[Signature]  
Notary Public  
Lorene A. Thornburg  
Printed Notary Name  
10/15/13  
My Commission Expires

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No. \_\_\_\_\_

FEIN: 46-1222808

**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).

CollabHealth Managed Solutions, Inc.  
198 Inverness Drive West  
Englewood, CO 80112  
Ph: 720-874-1293

1. Affiant's Full Name (Initials Not Acceptable). Nicholas Michael Barto
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.

<u>Beginning/Ending Date(s) Used (MM/YY)</u>	<u>Name(s)</u>	<u>Reason (If None, indicate such)</u>
<u>1972 - 1975</u>	<u>Nicholas M. Bartolomocci</u>	<u>NONE</u>
_____ - _____	_____	_____
_____ - _____	_____	_____
_____ - _____	_____	_____
_____ - _____	_____	_____
_____ - _____	_____	_____
_____ - _____	_____	_____
_____ - _____	_____	_____
_____ - _____	_____	_____
_____ - _____	_____	_____

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.

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 Teaneck  
State/Province NJ Country USA
7. Name of Affiant's Spouse (if applicable) Nancy Clare Morgan

**Confidential  
Personal Information**

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No. \_\_\_\_\_

FEIN \_\_\_\_\_

46-1222808

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
06/12-present	[REDACTED]	Denver	CO	USA	80210
2003-2012	[REDACTED]	Charlotte	NC	USA	28209

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 address to another.

Dated and signed this 14<sup>th</sup> day of DECEMBER, 20 12 at 198 Inverness Drive West, Englewood, CO 80112, 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.

[Signature]  
(Signature of Affiant)

State of Colorado County of Arapahoe

The foregoing instrument was acknowledged before me this 14<sup>th</sup> day of Dec, 20 12 By

Nicholas Michael Barta and:

- who is personally known to me, or
- who produced the following identification: \_\_\_\_\_

[SEAL] LORENE A. THORNBURG  
 NOTARY PUBLIC  
 STATE OF COLORADO  
 My Commission Expires 10/15/2013

Lorene A. Thornburg  
 Notary Public  
Lorene A. Thornburg  
 Printed Notary Name  
10/15/2013  
 My Commission Expires

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No.

FEIN:

46-1222808

**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 CollabHealth Managed Solutions, 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 Corporate Counsel, 198 Inverness Dr. West, Englewood CO 80112 Ph: 303-383-2615.

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.

Nicholas Michael Barto, [REDACTED] Denver, CO 80210

(Printed Full Name and Residence Address)

[Signature]  
(Signature)

12/14/12  
(Date)

State of Colorado County of Arapahoe

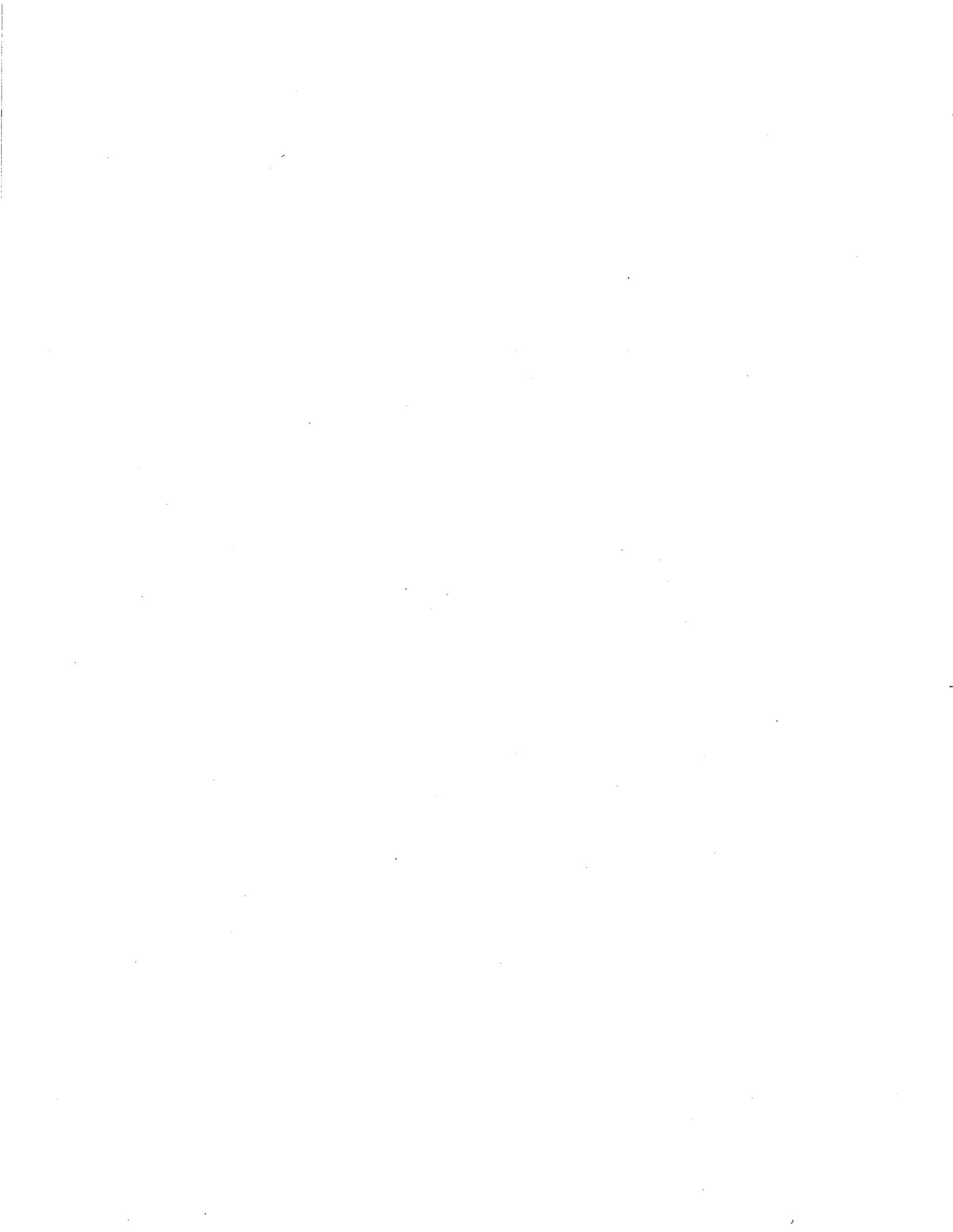
The foregoing instrument was acknowledged before me this 14<sup>th</sup> day of DEC 2012 By Nicholas Michael Barto, and

who is personally known to me, or

who produced the following identification: \_\_\_\_\_

[SEAL] LORENE A. THORNBURG  
NOTARY PUBLIC  
STATE OF COLORADO  
My Commission Expires 10/15/2013

[Signature]  
Notary Public  
Lorene A Thornburg  
Printed Notary Name  
10/15/2013  
My Commission Expires



**Confidential  
Personal Information**

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No. \_\_\_\_\_

FEIN \_\_\_\_\_

46-1222808

**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).

CollabHealth Managed Solutions, Inc.  
198 Inverness Drive West  
Englewood, CO 80112  
Ph: 720-874-1293

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). John Frank DiCola
2. a. Are you a citizen of the United States? Yes
- b. Are you a citizen of any other country, if so, what country? \_\_\_\_\_
3. Affiant's Occupation or Profession. Health Care Executive
4. Affiant's business address. Catholic Health Initiatives, 198 Inverness Drive West, Englewood CO 80112  
Business telephone. 303-383-2679
5. Education and Training:

<u>College/ University</u>	<u>City/ State</u>	<u>Dates Attended (MM/YY)</u>	<u>Degree Obtained</u>
University of Notre Dame	Notre Dame IN	9/69-6/73	Bachelor of Arts

<u>Graduate Studies:</u>	<u>College/ University</u>	<u>City/ State</u>	<u>Dates Attended (MM/YY)</u>	<u>Degree Obtained</u>
	Indiana University	Bloomington IN	1/78-5/79	Master of Public Affairs

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

(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.)

**Confidential  
Personal Information**

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No. \_\_\_\_\_

FEIN: 46-1222808

6. List of memberships in professional societies and associations.

<u>Name of Society/Association</u>	<u>Contact Name</u>	<u>Address of Society/Association</u>	<u>Telephone Number of Society/Association</u>
Society for Healthcare Strategy and Market Development	Emily McCracken Lee	AHA 155 N. Wacker Drive Suite 400 Chicago IL 60606	312-422-3888
American College of Health Care Executives	Alicia Borsa	One North Franklin St Suite 1700 Chicago, IL 60606	312-424-2800

7. Present or proposed position with the applicant entity. Board Member

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) 05/96- Present Employer's Name Catholic Health Initiatives

Address 198 Inverness Drive West City Englewood State/Province Colorado

Country USA Postal Code 80112 Phone (303) 383-2679 Offices/Positions Held SVP Strategy & Bus. Devel.

Supervisor / Contact Kevin Lofton, President & CEO 303-383-2640

Beginning/Ending

Dates (MM/YY) 11/87-04/96 Employer's Name Sisters of Charity Health Care Systems, Inc.

Address 345 Neeb Road City Cincinnati State/Province OH

Country USA Postal Code 45233 Phone NA Offices/Positions Held VP-Strategic Development

Supervisor / Contact NA \_\_\_\_\_

Beginning/Ending

Dates (MM/YY) \_\_\_\_\_ - \_\_\_\_\_ Employer's Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State/Province \_\_\_\_\_

Country \_\_\_\_\_ Postal Code \_\_\_\_\_ Phone \_\_\_\_\_ Offices/Positions Held \_\_\_\_\_

Supervisor / Contact \_\_\_\_\_

Beginning/Ending

Dates (MM/YY) \_\_\_\_\_ - \_\_\_\_\_ Employer's Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State/Province \_\_\_\_\_

Country \_\_\_\_\_ Postal Code \_\_\_\_\_ Phone \_\_\_\_\_ Offices/Positions Held \_\_\_\_\_

Supervisor / Contact \_\_\_\_\_

**Confidential  
Personal Information**

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No. \_\_\_\_\_

FEIN 46-1222808

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

**Confidential**  
**Personal Information**

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No. \_\_\_\_\_

FEIN: 46-1222808

- 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. NO \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

**Confidential**  
**Personal Information**

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No. \_\_\_\_\_

FEIN 46-1222808

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.

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 11<sup>th</sup> day of December, 2012 at Englewood CO. 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.

*John Frank DiCola*

\_\_\_\_\_  
(Signature of Affiant)

State of Colorado County of Arapahoe

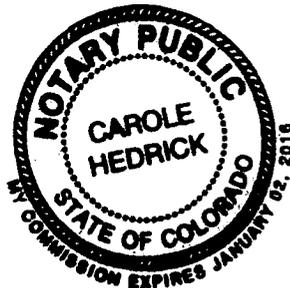
The foregoing instrument was acknowledged before me this 17<sup>th</sup> day of Dec, 2012 By

John Frank DiCola, and:

who is personally known to me, or

who produced the following identification: \_\_\_\_\_

[SEAL]



*Carole Hedrick*

Notary Public

*Carole Hedrick*

Printed Notary Name

Jan 2, 2016

My Commission Expires

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No. \_\_\_\_\_

FEIN: 46-1222808

**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).

CollabHealth Managed Solutions, Inc.  
198 Inverness Drive West  
Englewood, CO 80112  
Ph: 720-874-1293

- Affiant's Full Name (Initials Not Acceptable). John Frank DiCola
- Have you ever used any other name including nickname, maiden name or aliases? No If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

<u>Beginning/Ending Date(s) Used (MM/YY)</u>	<u>Name(s)</u>	<u>Reason (If None, indicate such)</u>
_____ - _____	_____	_____
_____ - _____	_____	_____
_____ - _____	_____	_____
_____ - _____	_____	_____
_____ - _____	_____	_____
_____ - _____	_____	_____
_____ - _____	_____	_____
_____ - _____	_____	_____
_____ - _____	_____	_____
_____ - _____	_____	_____

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.

- Affiant's Social Security Number [REDACTED]
- Government Identification Number if not a U.S. Citizen \_\_\_\_\_
- Foreign Student ID# (if applicable) \_\_\_\_\_
- Date of Birth: (MM/DD/YY) [REDACTED] Place of Birth: City Fort Wayne  
State/Province Indiana Country USA
- Name of Affiant's Spouse (if applicable) Linda R. Redding

**Confidential  
Personal Information**

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No. \_\_\_\_\_

FEIN \_\_\_\_\_

46-1222808

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
------------------	---------	------	--------------------	---------	-------------

	[REDACTED]	Littleton	CO	USA	80128
--	------------	-----------	----	-----	-------

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 address to another.

Dated and signed this 17th day of Dec., 2012 at Englewood 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.

[Signature]  
(Signature of Affiant)

State of Colorado County of Arapahoe

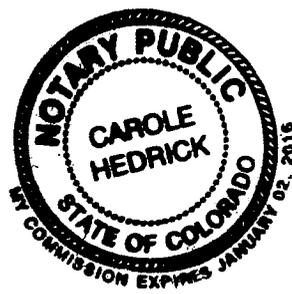
The foregoing instrument was acknowledged before me this 17th day of Dec., 2012 By

John Frank DiCola, and:

who is personally known to me, or

who produced the following identification: \_\_\_\_\_

[SEAL]



Carole Hedrick

Notary Public

Carole Hedrick

Printed Notary Name

Jan. 2, 2016

My Commission Expires

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No. \_\_\_\_\_

FEIN: 46-1222808

**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 CollabHealth Managed Solutions, 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 Corporate Counsel, 198 Inverness Dr. West, Englewood CO 80112 Ph: 303-383-2615.

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)  
John Frank DiCola  
(Signature) December 17, 2012  
(Date)

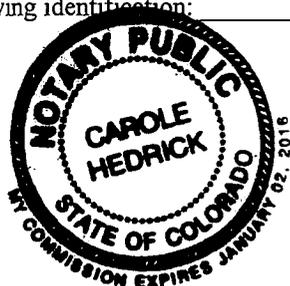
State of CO County of Arapahoe

The foregoing instrument was acknowledged before me this 17th day of Dec, 20 12 By John Frank DiCola, and

who is personally known to me, or

who produced the following identification: \_\_\_\_\_

[SEAL]



Carole Hedrick  
Notary Public  
Carole Hedrick  
Printed Notary Name  
Jan. 2, 2016  
My Commission Expires



**Confidential  
Personal Information**

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No. \_\_\_\_\_

FEIN \_\_\_\_\_

46-1222808

**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).

CollabHealth Managed Solutions, Inc.  
198 Inverness Drive West  
Englewood, CO 80112  
Ph: 720-874-1293

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). Thomas Clifford Deveny M.D.

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

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

3. Affiant's Occupation or Profession. Healthcare Executive, Catholic Health Initiatives

4. Affiant's business address. 198 Inverness drive, West, Englewood, Colorado 80112 \_\_\_\_\_

Business telephone. 303-383-2658 \_\_\_\_\_

5. Education and Training:

<u>College/ University</u>	<u>City/ State</u>	<u>Dates Attended (MM/YY)</u>	<u>Degree Obtained</u>
Denison University	Granville, Ohio	Sept 1978-Jun 1982	B.A. Chemistry

<u>Graduate Studies:</u>	<u>College/ University</u>	<u>City/ State</u>	<u>Dates Attended (MM/YY)</u>	<u>Degree Obtained</u>
Medical degree	Medical College of Ohio	Toledo, Ohio	Sept 1982-June 1986	M.D.

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

(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.)

**Confidential  
Personal Information**

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No. \_\_\_\_\_  
FEIN: 46-1222808

6. List of memberships in professional societies and associations.

<u>Name of Society/Association</u>	<u>Contact Name</u>	<u>Address of Society/Association</u>	<u>Telephone Number of Society/Association</u>
American Congress of Ob/Gyn	Hal Lawrence M.D.	409 12 <sup>th</sup> st. SW, Washington DC 20024-2188	1-800-673-8444

7. Present or proposed position with the applicant entity. Board Member \_\_\_\_\_

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) May 2011 - present \_\_\_ Employer's Name Catholic Health Initiatives \_\_\_\_\_

Address 198 Inverness Drive West \_\_\_ City Englewood \_\_\_\_\_ State/Province Colorado \_\_\_\_\_

Country USA \_\_\_ Postal Code 80112 \_\_\_ Phone 303-383-2658 Offices/Positions Held SVP, Physician Services

Supervisor / Contact Michael Rowan, Chief Operating Officer / 303-383-2630 \_\_\_\_\_

Beginning/Ending

Dates (MM/YY) June/1996 - May 2011 \_\_\_ Employer's Name Summa Health System \_\_\_\_\_

Address 525 East Market Street \_\_\_ City Akron \_\_\_\_\_ State/Province Ohio \_\_\_\_\_

Country USA \_\_\_ Postal Code 44309 \_\_\_ Phone 330-375-3000 Offices/Positions Held President, Summa Physicians Inc., VP Physician Alignment, VP Clinical Services and Service Lines, Chair Ob/Gyn Department \_\_\_\_\_

Supervisor / Contact Thomas Strauss-CEO/330-375-3000 \_\_\_\_\_

Beginning/Ending

Dates (MM/YY) July 1990 - Sept 2002 \_\_\_ Employer's Name Valley Obstetrics and Gynecology Inc. \_\_\_\_\_

Address 1611-C, Akron Peninsula Road \_\_\_ City Akron \_\_\_\_\_ State/Province Ohio \_\_\_\_\_

Country USA \_\_\_ Postal Code 44313 \_\_\_ Phone 330-928-0346 Offices/Positions Held employed physician/owner \_\_\_\_\_

Supervisor / Contact Ernest Estep M.D.-President/330-666-2366 \_\_\_\_\_

Beginning/Ending

Dates (MM/YY) N/A \_\_\_ - N/A \_\_\_ Employer's Name N/A \_\_\_\_\_

Address N/A \_\_\_ City N/A \_\_\_ State/Province N/A \_\_\_\_\_

Country N/A \_\_\_ Postal Code N/A \_\_\_ Phone N/A \_\_\_ Offices/Positions Held N/A \_\_\_\_\_

**Confidential  
Personal Information**

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No. \_\_\_\_\_

FEIN 46-1222808

Supervisor / Contact N/A \_\_\_\_\_

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. 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 \_\_\_\_\_
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

Organization/Issuer of License State of Ohio Medical Board Address 30 East Broad St, 3<sup>rd</sup> Floor

City Columbus State/Province Ohio Country USA Postal Code 43215-6127

License Type Medical Doctor License # 35055608 Date Issued (MM/YY) June 1987

Date Expired (MM/YY) April 2013(current) Reason for Termination still current

Non-insurance Regulatory Phone Number (if known) www.med.ohio.gov

Organization /Issuer of License n/a Address n/a

City n/a State/Province n/a Country n/a Postal Code n/a

License Type n/a License # n/a Date Issued (MM/YY) n/a

Date Expired (MM/YY) n/a Reason for Termination n/a

Non-insurance Regulatory Phone Number (if known) n/a

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

**Confidential  
Personal Information**

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No. \_\_\_\_\_

FEIN: 46-1222808

- 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 \_\_\_\_\_

- 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. N/A \_\_\_\_\_

- 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.  
No \_\_\_\_\_

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

N/A \_\_\_\_\_

**Confidential  
Personal Information**

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No. \_\_\_\_\_  
FEIN 46-1222808

14. Have you ever been adjudged a bankrupt? No \_\_\_\_\_ If yes, provide details N/A \_\_\_\_\_

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.

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 twelfth 12/14/2012 day of December 2012 at Englewood, Colorado 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.

[Signature]  
(Signature of Affiant)

State of Colorado County of Arapahoe

The foregoing instrument was acknowledged before me this 13th day of Dec., 2012 By

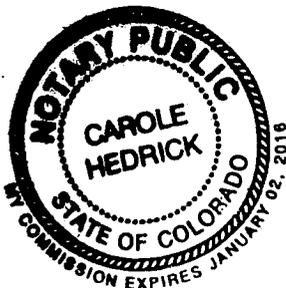
Thomas Clifford Deveny, and:

who is personally known to me, or

who produced the following identification: \_\_\_\_\_

[SEAL]

[Signature]  
Notary Public  
Carole Hedrick  
Printed Notary Name  
January 2, 2016  
My Commission Expires



**Confidential  
Personal Information**

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No. \_\_\_\_\_  
FEIN: 46-1222808

**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).

CollabHealth Managed Solutions, Inc.  
198 Inverness Drive West  
Englewood, CO 80112  
Ph: 720-874-1293

1. Affiant's Full Name (Initials Not Acceptable). Thomas Clifford Deveny \_\_\_\_\_
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.

<u>Beginning/Ending Date(s) Used (MM/YY)</u>	<u>Name(s)</u>	<u>Reason (If None, indicate such)</u>
6/1982 - present	T. Clifford Deveny	None
-	-	-
-	-	-
-	-	-
-	-	-
-	-	-
-	-	-
-	-	-
-	-	-
-	-	-

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.

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 Pittsburgh \_\_\_\_\_  
State/Province Pennsylvania \_\_\_\_\_ Country USA \_\_\_\_\_
7. Name of Affiant's Spouse (if applicable) Sandra Lopina Deveny \_\_\_\_\_

**Confidential  
Personal Information**

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No. \_\_\_\_\_

FEIN \_\_\_\_\_

46-1222808

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
5/2011-present	[REDACTED]	Carbondale	Colorado	USA	81623
6/1990-5/2011	[REDACTED]	Akron Ohio		USA	44333

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 address to another.

Dated and signed this twelfth day of December, 2012 at Englewood, Colorado 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.

[Signature]  
(Signature of Affiant)

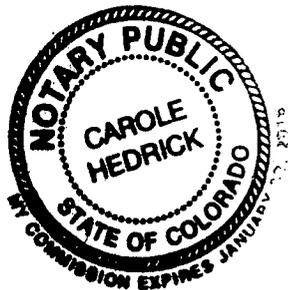
State of Colorado County of Arapahoe

The foregoing instrument was acknowledged before me this 13th day of Dec, 2012 By Thomas Clifford  
Deveny, and:

who is personally known to me, or

who produced the following identification: \_\_\_\_\_

[SEAL]



[Signature]  
Notary Public  
Carole Hedrick  
Printed Notary Name  
January 2, 2016  
My Commission Expires

**Confidential  
Personal Information**

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No. \_\_\_\_\_

FEIN: 46-1222808

**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 CollabHealth Managed Solutions, Inc. 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 Corporate Counsel, 198 Inverness Dr. West, Englewood CO 80112 Ph: 303-383-2615.

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.

THOMAS CLIFFORD DEVENY CARBONDALE COLORADO  
(Printed Full Name and Residence Address) (162)

[Signature]  
(Signature)

12/13/2012  
(Date)

State of Colorado County of ARAPAHOE

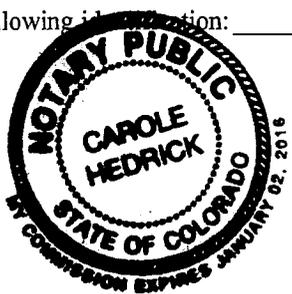
The foregoing instrument was acknowledged before me this 13th day of Dec 2012 By

Thomas Clifford, and  
Deveny

who is personally known to me, or

who produced the following information: \_\_\_\_\_

[SEAL]



Carole Hedrick  
Notary Public  
Carole Hedrick  
Printed Notary Name  
January 2, 2016  
My Commission Expires

**Confidential  
Personal Information**

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No. \_\_\_\_\_

FEIN 46-1222808

**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 CollabHealth Managed Solutions, 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 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 Corporate Counsel, 198 Inverness Dr. West, Englewood CO 80112 Ph: 303-383-2615.

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.

THOMAS CLIFFORD DEVENY ██████████ CARBONDALE, CO 81623  
(Printed Full Name and Residence Address)

[Signature]  
(Signature)

12/13/2012  
(Date)

State of COLORADO County of ARAPAHOE

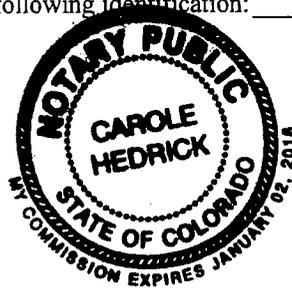
The foregoing instrument was acknowledged before me this 13th day of Dec, 2012 By

Thomas Clifford Deveny, and

who is personally known to me, or

who produced the following identification: \_\_\_\_\_

[SEAL]



Carole Hedrick  
Notary Public  
Carole Hedrick  
Printed Notary Name  
January 2, 2016  
My Commission Expires



**Confidential  
Personal Information**

Applicant Name (Company) CollabHealth Managed Solutions, Inc. -

NAIC No.

FEIN

46-1222808

**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).

CollabHealth Managed Solutions, Inc.  
198 Inverness Drive West  
Englewood, CO 80112  
Ph: 720-874-1293

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). Michael Terrance Rowan

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

b. Are you a citizen of any other country, if so, what country? \_\_\_\_\_

3. Affiant's Occupation or Profession: Hospital Executive

4. Affiant's business address. 198 Inverness Drive West

Business telephone. 303-383-2630

5. Education and Training:

<u>College/ University</u>	<u>City/ State</u>	<u>Dates Attended (MM/YY)</u>	<u>Degree Obtained</u>
Miami University	Oxford, OH	09/76-06/80	B.S. Business Administration

<u>Graduate Studies:</u>	<u>College/ University</u>	<u>City/ State</u>	<u>Dates Attended (MM/YY)</u>	<u>Degree Obtained</u>
	University of Michigan.	Ann Arbor, MI	09/80-05/82	MHA Hospital Administration

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

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No. \_\_\_\_\_

FEIN: 46-1222808

6. List of memberships in professional societies and associations.

<u>Name of Society/Association</u>	<u>Contact Name</u>	<u>Address of Society/Association</u>	<u>Telephone Number of Society/Association</u>
<u>American Hospital Association</u>	<u>Unknown</u>	<u>155 North Wacker Drive #400, Chicago, IL 60606</u>	<u>312-422-3000</u>
<u>American College of Healthcare Executives</u>	<u>Unknown</u>	<u>Suite 1700 One North Franklin Street Chicago, IL 60606-3529</u>	<u>(312) 424-2800</u>
<u>National Association of Health Services Executives</u>	<u>Unknown</u>	<u>1050 Connecticut Ave. NW 10<sup>th</sup> Floor Washington, DC 20036</u>	<u>202.772.1030</u>

7. Present or proposed position with the applicant entity. Corporate Officer of parent organization

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) 02/04-Present Employer's Name Catholic Health Initiatives

Address 198 Inverness Drive West City Englewood State/Province CO

Country United States Postal Code 80112 Phone 303-383-2630 Offices/Positions Held Chief Operations Officer

Supervisor / Contact Kevin Lofton, President phone: 303.383.2640

Beginning/Ending

Dates (MM/YY) 10/02- 02/04 Employer's Name St. John Providence Health Systems

Address Building 28000 Dequindre City Warren State/Province Michigan

Country United States Postal Code 48092 Phone 586-753-0500 Offices/Positions Held Chief Operating Officer

Supervisor / Contact Elliot Joseph Phone: Unknown

Beginning/Ending

Dates (MM/YY) 08/99- 10/02 Employer's Name Humility of Mary Health Care

Address 1044 Belmont Avenue City Youngstown State/Province OHIO

Country United States Postal Code 44504 Phone 330-746-7211 Offices/Positions Held President

Supervisor / Contact Gary Campbell

Beginning/Ending

Dates (MM/YY) 01/93 - 06/99 Employer's Name Sarasota Memorial Hospital

Address 1700 S. Tamiami Trail City Sarasota State/Province Florida

Country United States Postal Code 34239 Phone 941-917-9000 Offices/Positions Held Chief Operating Officer

**Confidential  
Personal Information**

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No. \_\_\_\_\_

FEIN \_\_\_\_\_

46-1222808

Supervisor / Contact Michael Covert

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

Organization/Issuer of License N/A Address N/A

City N/A State/Province N/A Country N/A Postal Code N/A

License Type N/A License # N/A Date Issued (MM/YY) N/A

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

Non-insurance Regulatory Phone Number (if known) N/A

Organization /Issuer of License N/A Address N/A

City N/A State/Province N/A Country N/A Postal Code N/A

License Type N/A License # \_\_\_\_\_ Date Issued (MM/YY) N/A

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

Non-insurance Regulatory Phone Number (if known) N/A

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

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

**Confidential**  
**Personal Information**

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No. \_\_\_\_\_

FEIN: 46-1222808

- 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. NO

\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

**Confidential  
Personal Information**

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No.

FEIN

46-1222808

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.

- a. Been refused a permit, license, or certificate of authority by any regulatory authority, or Governmental-licensing agency? None
- 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)? None
- 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? None

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 13th day of December 2012 at 4:00pm 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.

Michael Terrance Rowan  
(Signature of Affiant)

State of Colorado County of Arapahoe

The foregoing instrument was acknowledged before me this 13<sup>th</sup> day of December, 2012 By Michael Terrance Rowan, and:

who is personally known to me, or

who produced the following identification: \_\_\_\_\_

[SEAL]



Kerry S. Harris  
Notary Public  
Kerry S. Harris  
Printed Notary Name

My Commission Expires \_\_\_\_\_

**Confidential  
Personal Information**

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No. \_\_\_\_\_

FEIN: 46-1222808

**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).

CollabHealth Managed Solutions, Inc.  
198 Inverness Drive West  
Englewood, CO 80112  
Ph: 720-874-1293

1. Affiant's Full Name (Initials Not Acceptable). Michael Terrance Rowan
2. Have you ever used any other name including nickname, maiden name or aliases? NO If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

<u>Beginning/Ending Date(s) Used (MM/YY)</u>	<u>Name(s)</u>	<u>Reason (If None, indicate such)</u>
_____ - _____	_____	_____
_____ - _____	_____	_____
_____ - _____	_____	_____
_____ - _____	_____	_____
_____ - _____	_____	_____
_____ - _____	_____	_____
_____ - _____	_____	_____
_____ - _____	_____	_____
_____ - _____	_____	_____
_____ - _____	_____	_____

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.

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 Indianapolis  
State/Province Indiana Country USA

7. Name of Affiant's Spouse (if applicable) Patrice Rowan
8. List your residences for the last ten (10) years starting with your current address, giving:

Beginning/Ending

**Confidential  
Personal Information**

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No. \_\_\_\_\_

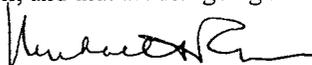
FEIN \_\_\_\_\_

46-1222808

Dates (MM/YY)	Address	City	State/ Province	Country	Postal Code
06/06-Present	[REDACTED]	Denver	CO	USA	80230
02/04-06/06	[REDACTED]	Highlands Ranch	CO	USA	80126
10/02-02/04	[REDACTED]	Orchard lake	MI	USA	48323

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 address to another.

Dated and signed this 13th day of , 2012 at 4pm. 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.



(Signature of Affiant)

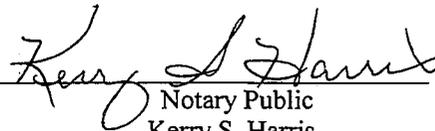
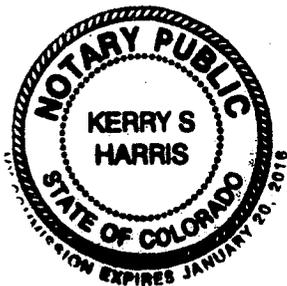
State of Colorado County of Arapahoe

The foregoing instrument was acknowledged before me this 13th day of **December, 2012** By

Michael Terrance Rowan, and:

who is personally known to me, or

who produced the following identification: \_\_\_\_\_



Notary Public  
Kerry S. Harris

Printed Notary Name

January 20, 2016

My Commission Expires

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No.

FEIN:

46-1222808

**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 CollabHealth Managed Solutions, 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 Corporate Counsel, 198 Inverness Dr. West, Englewood CO 80112 Ph: 303-383-2615.

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.

Michael Terrance Rowan, [REDACTED] Denver, CO 80230  
(Printed Full Name and Residence Address)

[Signature]  
(Signature)

December 13, 2012  
(Date)

State of Colorado County of Arapahoe

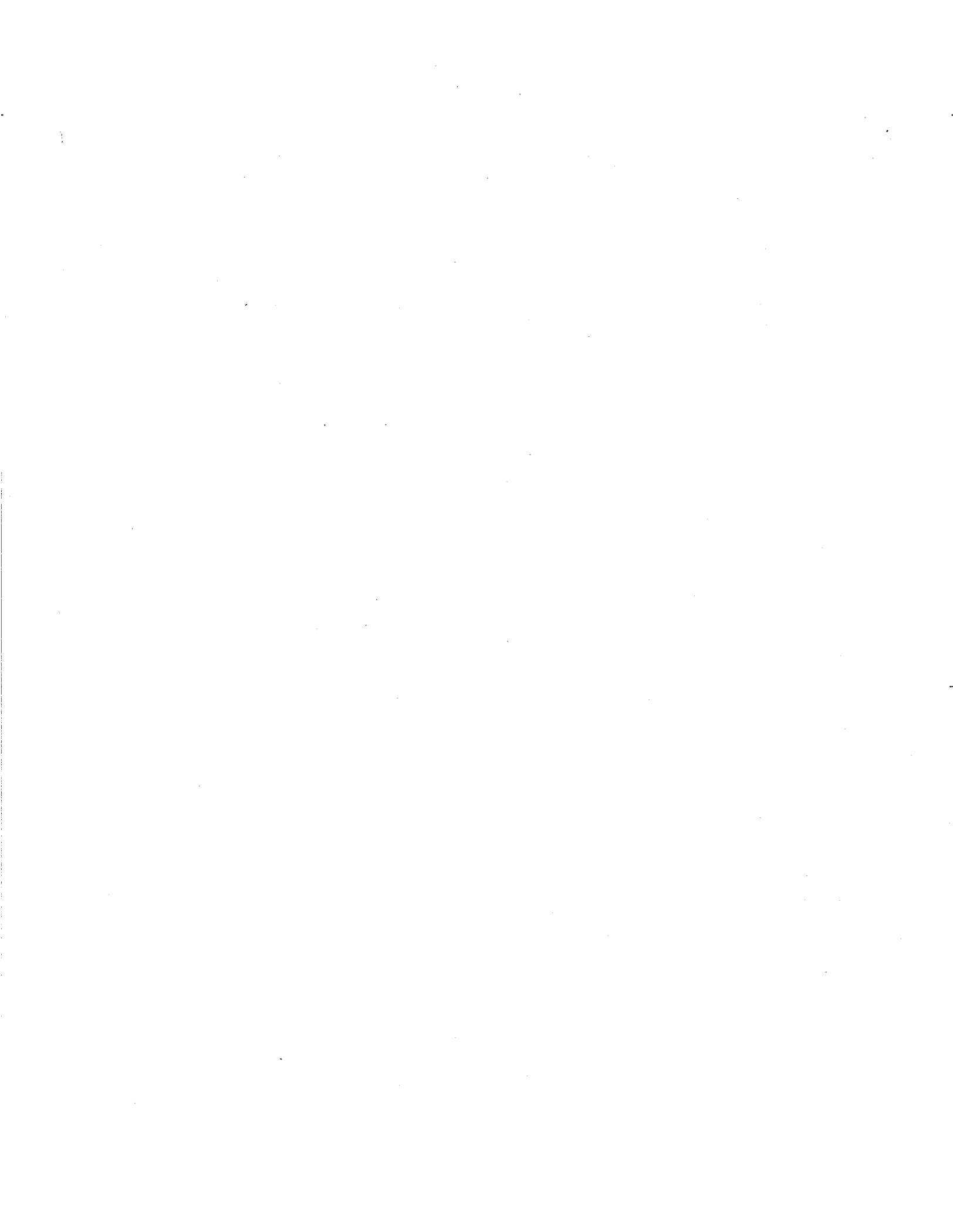
The foregoing instrument was acknowledged before me this 13<sup>th</sup> day of December 2012 By Michael Terrance Rowan and

who is personally known to me, or

who produced the following identification: \_\_\_\_\_



[Signature]  
Notary Public  
Kerry S. Harris  
Printed Notary Name  
January 20, 2016  
My Commission Expires



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).

CollabHealth Managed Solutions, Inc.  
198 Inverness Drive West  
Englewood, CO 80112  
Ph: 720-874-1293

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). Robert G. Strickland
- 2. a. Are you a citizen of the United States? YES
- b. Are you a citizen of any other country, if so, what country? \_\_\_\_\_

3. Affiant's Occupation or Profession. SVP, Performance Excellence Group

4. Affiant's business address. 198 Inverness Drive West, Englewood, CO 80112

Business telephone. 720.874.1184

5. Education and Training:

<u>College/ University</u>	<u>City/ State</u>	<u>Dates Attended (MM/YY)</u>	<u>Degree Obtained</u>
<u>Northwestern University, Evanston, Illinois</u>	<u>Illinois</u>	<u>June 20, 1997</u>	<u>Master of Management (MBA)</u>
<u>Florida State University, Tallahassee, Florida</u>	<u>Florida</u>	<u>December 14, 1979</u>	<u>Master of Arts</u>
<u>Florida State University, Tallahassee, Florida</u>	<u>Florida</u>	<u>June 11, 1977</u>	<u>Bachelor of Arts</u>

<u>Graduate Studies:</u>	<u>College/ University</u>	<u>City/ State</u>	<u>Dates Attended (MM/YY)</u>	<u>Degree Obtained</u>
--------------------------	----------------------------	--------------------	-------------------------------	------------------------

<u>Other Training: Name</u>	<u>City/ State</u>	<u>Dates Attended (MM/YY)</u>	<u>Degree/Certification Obtained</u>
<u>Leading Edge Group / University of Denver, Colorado</u>	<u>Colorado</u>	<u>2008</u>	
<u>Six Sigma Black Belt / ASQC</u>		<u>2007</u>	

(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.)

Personal Information

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No. \_\_\_\_\_

FEIN: 46-1222808

6. List of memberships in professional societies and associations.

<u>Name of Society/Association</u>	<u>Contact Name</u>	<u>Address of Society/Association</u>	<u>Telephone Number of Society/Association</u>

7. Present or proposed position with the applicant entity. \_\_\_\_\_

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) 2004 - Present Employer's Name Catholic Health Initiatives / Senior Vice President / Vice President, Operations Improvement / Senior Operations Consultant 2004-Present / 198 Inverness Drive West, Englewood, CO 80112

Beginning/Ending

Dates (MM/YY) 2003 - 2004 Employer's Name Wellcare, Inc. / Sr. Vice President, Operations 2003-2004 / 8735 Henderson Road, Tampa, FL 33634 / 813.290.6200

Beginning/Ending

Dates (MM/YY) 2000 - 2003 Employer's Name Healthplan Southeast / Vista Healthplan / Vice President, Network Development and Provide Relations 2000-2003 / Executive Director, Healthplan Southeast (A Division of Vista Healthplan 2003/ COMPANY CURRENTLY OUT OF BUSINESS - SOLD TO COVENANT HEALTH PLANS

Beginning/Ending

Dates (MM/YY) 1993 - 2000 Employer's Name Wheaton Franciscan Healthcare / Senior Vice President, Performance Improvement 1993-1995 / Sr. Vice President, Corporate Services 1995-1996 / President/CEO, FMI 1998-2000 / Sr. Vice President, Operations 1996-2000 / 26 W. 171 Roosevelt Road, Wheaton, IL 60189 / 630.909.6900

Beginning/Ending

Dates (MM/YY) 1990 - 1993 Employer's Name Quorum Health Resources / Corporate Vice President & Leader, Center for Continuous Improvement 1992-1993 / Operations Manager 1991-1992 / Director, Center for Continuous Improvement Learning Institute 1990-1991 / 105 Continental Place, Brentwood, TN 37027 / 615.371.7979

Beginning/Ending

Dates (MM/YY) 1985 - 1990 Employer's Name HCA Management Company / Director, Continuous Improvement Theory and Methods 1985-1990 / Senior Consultant 1988 / 1 Park Plz, Nashville, TN 37203 / 615.344.9551

Address \_\_\_\_\_ City \_\_\_\_\_ State/Province \_\_\_\_\_

Country \_\_\_\_\_ Postal Code \_\_\_\_\_ Phone \_\_\_\_\_ Offices/Positions Held \_\_\_\_\_

Supervisor / Contact \_\_\_\_\_

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No.

FEIN

46-1222808

- 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** \_\_\_\_\_
- 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. **NO** \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No.

FEIN

46-1222808

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.

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or Governmental-licensing agency? NO Wellcare was fined by the Federal government and restricted, but it was after I left.

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 See above.

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 17 day of Dec 2012 at 198 Inverness Dr. West Englewood Co 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.

[Signature]  
(Signature of Affiant)

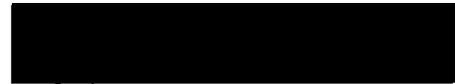
State of Colorado County of Arapahoe

The foregoing instrument was acknowledged before me this 17<sup>th</sup> day of Dec, 2012 By

Robert Glenn Strickland and:

who is personally known to me, or

who produced the following identification: Robert Glenn Strickland



[SEAL]

Amber Eruchalu  
State of Colorado  
Notary Public  
Commission No. 20084006779  
My Commission Expires 2/25/2016

Amber Eruchalu  
Notary Public  
Amber Eruchalu  
Printed Notary Name  
2/25/2016  
My Commission Expires

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No.

FEIN:

46-1222808

**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).

CollabHealth Managed Solutions, Inc.  
198 Inverness Drive West  
Englewood, CO 80112  
Ph: 720-874-1293

1. Affiant's Full Name (Initials Not Acceptable). Robert Glenn Strickland
2. Have you ever used any other name including nickname, maiden name or aliases? Bob If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

<u>Beginning/Ending Date(s) Used (MM/YY)</u>	<u>Name(s)</u>	<u>Reason (If None, indicate such)</u>
_____ - _____	_____	_____
_____ - _____	_____	_____
_____ - _____	_____	_____
_____ - _____	_____	_____
_____ - _____	_____	_____
_____ - _____	_____	_____
_____ - _____	_____	_____
_____ - _____	_____	_____
_____ - _____	_____	_____
_____ - _____	_____	_____

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.

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 Pensacola  
State/Province Florida Country \_\_\_\_\_
7. Name of Affiant's Spouse (if applicable) Dena Strickland

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No.

FEIN

46-1222808

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
------------------	---------	------	--------------------	---------	-------------

07/04 - Present [Redacted] Palm Harbor, FL USA 34683

04/11 - Present [Redacted] Centennial, CO USA 80112

08/00 - 07/04 [Redacted] Tallahassee, FL USA 32309

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 address to another.

Dated and signed this 17 day of Dec, 20 12 at 198 Inverness Dr. W. Englewood CO 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

[Handwritten Signature]

(Signature of Affiant)

State of Colorado County of Arapahoe

The foregoing instrument was acknowledged before me this 17th day of Dec, 20 12 By

Robert Glenn Strickland and:

[ ] who is personally known to me, or

[x] who produced the following identification: Robert Glenn Strickland [Redacted]

[SEAL]

Amber Eruchalu  
 State of Colorado  
 Notary Public  
 Commission No. 20084006779  
 My Commission Expires 2/25/2016

[Handwritten Signature: Amber Eruchalu]  
 Notary Public  
 Amber Eruchalu  
 Printed Notary Name  
 2/25/2016  
 My Commission Expires

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAC No. \_\_\_\_\_  
FEIN: 46-1222808

**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 CollabHealth Managed Solutions, 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 Corporate Counsel, 198 Inverness Dr. West, Englewood CO 80112 Ph: 303-383-2615.

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.

ROBERT GLENN STRICKLAND CENTENNIAL, CO 80112  
(Printed Full Name and Residence Address)

[Signature]  
(Signature)

12/17/12  
(Date)

State of Colorado County of Arapahoe

The foregoing instrument was acknowledged before me this 17<sup>th</sup> day of Dec 20 12 By Robert Glenn Strickland and

who is personally known to me, or

who produced the following identification: Robert Glenn Strickland [Redacted]

[SEAL]

Amber Eruchalu  
State of Colorado  
Notary Public  
Commission No. 20084006779  
My Commission Expires 2/25/2016

Amber Eruchalu  
Notary Public  
Amber Eruchalu  
Printed Notary Name  
2/25/2016  
My Commission Expires



BIOGRAPHICAL AFFIDAVIT

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

Mitch Henry Melfi

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).

CollabHealth Managed Solutions, Inc.
198 Inverness Drive West
Englewood, CO 80112
Ph: 720-874-1293

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). Mitch Henry Melfi
2. a. Are you a citizen of the United States? Yes
b. Are you a citizen of any other country, if so, what country? No
3. Affiant's Occupation or Profession. Attorney
4. Affiant's business address. 198 Inverness Drive West, Englewood, CO 80112
Business telephone. 303.383.2678

5. Education and Training:

Table with 4 columns: College/ University, City/ State, Dates Attended (MM/YY), Degree Obtained. Rows include Miami University and Ohio State University.

Table with 5 columns: Graduate Studies, College/ University, City/ State, Dates Attended (MM/YY), Degree Obtained. Row includes Capital Univer School of Law.

Table with 4 columns: 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.)

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No.

FEIN:

46-1222808

6. List of memberships in professional societies and associations.

<u>Name of Society/Association</u>	<u>Contact Name</u>	<u>Address of Society/Association</u>	<u>Telephone Number of Society/Association</u>
<u>Ohio Bar Association</u>		<u>PO Box 71081 Columbus, OH 43271-0781</u>	<u>800-232-7124</u>
<u>American Health Lawyers Association</u>		<u>1620 Eye St NW Washington, DC 20006-4010</u>	<u>202-833-1100</u>

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

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: Catholic Health Initiatives

Address 198 Inverness Drive West City Englewood State/Province CO

Country USA Postal Code 80112 Phone 303-298-9100 Offices/Positions Held General Counsel/Sr. Vice President

Supervisor / Contact: Kevin Lofton/303-383-2640

Beginning/Ending

Dates (MM/YY) 09/92 - 02/09 Employer's Name Catholic Health Initiatives

Address 3900 Olympic Blvd, Suite 400 City Erlanger State/Province KY

Country USA Postal Code 40402 Phone 859-594-3000 Offices/Positions Held: Sr VP/Risk&Insurance/Chief Risk Officer

Supervisor / Contact Michael Rowan/303-383-2720

Beginning/Ending

Dates (MM/YY) \_\_\_\_\_ - \_\_\_\_\_ Employer's Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State/Province \_\_\_\_\_

Country \_\_\_\_\_ Postal Code \_\_\_\_\_ Phone \_\_\_\_\_ Offices/Positions Held \_\_\_\_\_

Supervisor / Contact \_\_\_\_\_

Beginning/Ending

Dates (MM/YY) \_\_\_\_\_ - \_\_\_\_\_ Employer's Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State/Province \_\_\_\_\_

Country \_\_\_\_\_ Postal Code \_\_\_\_\_ Phone \_\_\_\_\_ Offices/Positions Held \_\_\_\_\_

Supervisor / Contact \_\_\_\_\_

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No. \_\_\_\_\_

FEIN \_\_\_\_\_

46-1222808

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? **NO** If yes, give details. \_\_\_\_\_  
\_\_\_\_\_

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

Organization/Issuer of License Ohio Supreme Court Address P.O Box 710781

City Columbus State/Province OH Country USA Postal Code 43271-0781

License Type Attorney License # 0014824 Date Issued (MM/YY) 10/84

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

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**

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?

**Confidential  
Personal Information**

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No. \_\_\_\_\_

FEIN: 46-1222808

- 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. NONE

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

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No. \_\_\_\_\_

FEIN \_\_\_\_\_

46-1222808

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.

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, except for administrative fines imposed in the course of routine market conduct or other examinations conducted and paid in the ordinary course of business of Preferred Professional Insurance Company

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 17th day of DEC 2012 at ENGLEWOOD 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.

*[Handwritten Signature]*

(Signature of Affiant)

State of Colorado County of Arapahoe

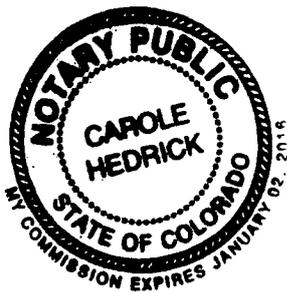
The foregoing instrument was acknowledged before me this 17th day of Dec., 2012 By

Mitch Henry Melfi and:

who is personally known to me, or

who produced the following identification: \_\_\_\_\_

[SEAL]



*[Handwritten Signature]*

Notary Public

Carole Hedrick

Printed Notary Name

Jan 2, 2016

My Commission Expires

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No. \_\_\_\_\_  
FEIN: 46-1222808

**BIOGRAPHICAL AFFIDAVIT**  
**Supplemental Personal Information**

**Mitch Henry Melfi**

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).

CollabHealth Managed Solutions, Inc.  
198 Inverness Drive West  
Englewood, CO 80112  
Ph: 720-874-1293

- Affiant's Full Name (Initials Not Acceptable). **Mitch Henry Melfi**
- Have you ever used any other name including nickname, maiden name or aliases? NO If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

<u>Beginning/Ending</u> <u>Date(s) Used (MM/YY)</u>	<u>Name(s)</u>	<u>Reason (If None, indicate such)</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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.

- Affiant's Social Security Number ██████████
- Government Identification Number if not a U.S. Citizen \_\_\_\_\_
- Foreign Student ID# (if applicable) \_\_\_\_\_
- Date of Birth: (MM/DD/YY) ██████████ Place of Birth: City Columbus  
State/Province Ohio Country USA
- Name of Affiant's Spouse (if applicable) Debra Ann Melfi

**Confidential**  
**Personal Information**

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No. \_\_\_\_\_

FEIN \_\_\_\_\_

46-1222808

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

<u>Beginning/Ending Dates</u> (MM/YY)	<u>Address</u>	<u>City</u>	<u>State/Province</u>	<u>Country</u>	<u>Postal Code</u>
06/10 to present	[REDACTED]	Lone Tree	CO	USA	80124
05/92 to present	[REDACTED]	Loveland	OH	USA	45140

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 address to another.

Dated and signed this 12<sup>th</sup> day of DEC., 2012 at ENGLEWOOD 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.

*[Handwritten Signature]*

(Signature of Affiant)

State of Colorado County of Arapahoe

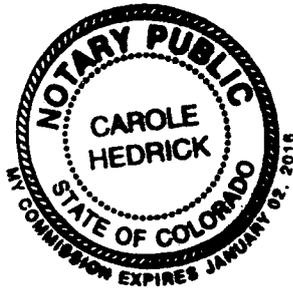
The foregoing instrument was acknowledged before me this 17<sup>th</sup> day of Dec., 2012 By

Mitch Henry Melfi, and:

who is personally known to me, or

who produced the following identification: \_\_\_\_\_

[SEAL]



Carole Hedrick  
Notary Public  
Carole Hedrick  
Printed Notary Name  
Jan. 2, 2016  
My Commission Expires

Applicant Name (Company) CollabHealth Managed Solutions, Inc.

NAIC No. \_\_\_\_\_  
FEIN: 46-1222808

**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 CollabHealth Managed Solutions, 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 Corporate Counsel, 198 Inverness Dr. West, Englewood CO 80112 Ph: 303-383-2615.

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.

Mitch Henry Melfi 198 Inverness Dr W Englewood, CO 80112

(Printed Full Name and Residence Address)

[Signature]

(Signature)

12/17/12

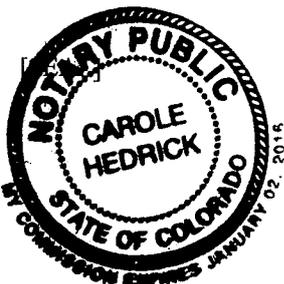
(Date)

State of CO County of Arapahoe

The foregoing instrument was acknowledged before me this 17th day of Dec. 2012 By Mitch Henry Melfi, and

who is personally known to me, or

who produced the following identification: \_\_\_\_\_



Carole Hedrick  
Notary Public  
Carole Hedrick  
Printed Notary Name  
Jan. 2, 2016  
My Commission Expires