

Applicant Name (Company) CollabHealth Plan Services, Inc.

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

FEIN: \_\_\_\_\_

**BIOGRAPHICAL AFFIDAVIT**

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

(Print or Type)

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

CollabHealth Plan Services, 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). Juan Ricardo Serrano
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 Management
4. Affiant's business address. 198 Inverness Drive West, Englewood, CO 80112  
Business telephone. 720-874-1239
5. Education and Training:

<u>College/ University</u>	<u>City/ State</u>	<u>Dates Attended (MM/YY)</u>	<u>Degree Obtained</u>	
<u>Baylor University</u>	<u>Waco, TX</u>	<u>08/1984-06/1987</u>	<u>BA, Business Administration</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>
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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 Plan Services, Inc.

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

FEIN: \_\_\_\_\_

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. Board Chair

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) 08/10- 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: National Vice President, Payer Strategy & Operations

Supervisor / Contact: Dean Swindle/303-383-2708

Beginning/Ending

Dates (MM/YY) 06/08- 01/10 Employer's Name: WellCare Health Plans

Address: 8725 Henderson Rd. City: Tampa State/Province: FL Country: USA

Postal Code: 33634 Phone: 813-290-6200 Offices/Positions Held: Vice President, Corporate Network Management

Supervisor / Contact: Dr. William Kerr/813-901-2201

Beginning/Ending

Dates (MM/YY) 02/06- 06/08 Employer's Name: Ovations

Address: 9900 Bren Rd. East City: Minnetonka State/Province: MN Country: USA Postal Code: 55343

Phone: 952-936-1300 Offices/Positions Held: Vice President, Secure Horizons Corporate Network Strategy

Supervisor / Contact: Brendan Baker/602-317-1624

Beginning/Ending

Dates (MM/YY) 03/04- 02/06 Employer's Name: United Healthcare of Texas

Address: 5800 Granite Pkwy. City: Plano State/Province: TX Country: USA

Postal Code: 75024 Phone: 469-633-8500 Offices/Positions Held: North Texas Market Executive Director

Supervisor / Contact: Tom Quirk/469-633-8500

Applicant Name (Company) CollabHealth Plan Services, Inc.

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

Beginning/Ending

Dates (MM/YY) 01/1998- 03/2004 Employer's Name: UnitedHealth Networks (UHN)

Address: 5901 Lincoln Dr. City: Edina State/Province: MN Country: USA

Postal Code: 55436 Phone: 952-992-7777 Offices/Positions Held: Vice President, Network Pricing and Operations

Supervisor / Contact: Stephan Rodgers/866-992-7777

Beginning/Ending

Dates (MM/YY) 02/1996- 12/1997 Employer's Name: Southern Healthcare

Address: 15 Baker St. 2001 Rosebank City: Johannesburg State/Province: \_\_\_ Country: South Africa

Postal Code: \_\_\_\_\_ Phone: 011-4414464 Offices/Positions Held: General Manger, Underwriting, Sales & Product Development and Client Relations

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

Beginning/Ending

Dates (MM/YY) 05/1995- 02/1996 Employer's Name: United Healthcare

Address: \_\_\_\_\_ City: Tampa State/Province: FL Country: USA

Postal Code: \_\_\_\_\_ Phone: \_\_\_\_\_ Offices/Positions Held: Director of Commercial Sales

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

Beginning/Ending

Dates (MM/YY) 07/1991- 05/1995 Employer's Name: United Healthcare

Address 5901 Lincoln Dr. City: Edina State/Province: MN Country: USA

Postal Code: 55436 Phone: 952-992-7777 Offices/Positions Held: Director of Group Underwriting

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

Beginning/Ending

Dates (MM/YY) 01/1989- 06/1991 Employer's Name: The Prudential Insurance Company

Address: 3701 Wayzata Blvd. City: Minneapolis State/Province: MN Country: USA

Postal Code: 55416 Phone: \_\_\_\_\_ Offices/Positions Held: Group Underwriter

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

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  
\_\_\_\_\_

Applicant Name (Company) CollabHealth Plan Services, Inc.

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

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
- 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

Applicant Name (Company) CollabHealth Plan Services, Inc.

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

- 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? YES

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.

State of Texas Sales Tax Lien

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. N/A

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. NO

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.

Applicant Name (Company) CollabHealth Plan Services, Inc.

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

FEIN: \_\_\_\_\_

Dated and signed this 12th day of Oct. 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.

[Signature]  
(Signature of Affiant)

State of Colorado County of Arapahoe

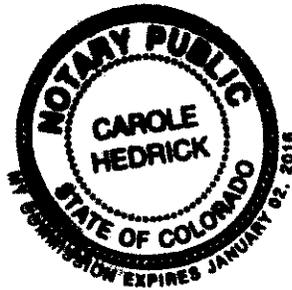
The foregoing instrument was acknowledged before me this 12th day of Oct., 2012 By

Juan Ricardo Serrano, 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

Applicant Name (Company) CollabHealth Plan Services, Inc.

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

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

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of CollabHealth Plan Services, 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.

JUAN RICARDO SEPRANO TAMPA FL 33607

(Printed Full Name and Residence Address)

[Signature]

(Signature)

October 12, 2012

(Date)

State of Colorado County of Arapahoe

The foregoing instrument was acknowledged before me this 12th day of Oct 2012 By

Juan Ricardo Serrano, 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

Applicant Name (Company) CollabHealth Plan Services, Inc.

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

**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 Plan Services, Inc.  
198 Inverness Drive West  
Englewood, CO 80112  
Ph: 720-874-1293

1. Affiant's Full Name (Initials Not Acceptable). Juan Ricardo Serrano
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 Minneapolis  
State/Province MN Country USA
7. Name of Affiant's Spouse (if applicable) Angela Marie Serrano

Applicant Name (Company) CollabHealth Plan Services, Inc.

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

FEIN: \_\_\_\_\_

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
07/2011	[REDACTED]	Tampa	FL	USA	33607
06/2008	[REDACTED]	Tampa	FL	USA	33626
07/2004	[REDACTED]	Frisco	TX	USA	75034
06/2002	[REDACTED]	Minnetonka	MN	USA	55345

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 12th day of Oct., 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.

[Signature]

(Signature of Affiant)

State of Colorado County of Arapahoe

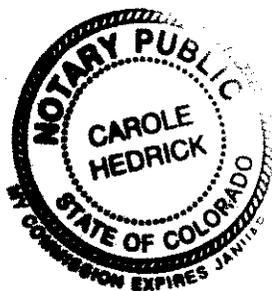
The foregoing instrument was acknowledged before me this 12th day of Oct., 2012 By

Ricardo Serrano, 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

NO. D-1-GV-10-001665

THE STATE OF TEXAS

VS.

JUAN RICARDO SERRANO

§  
§  
§  
§  
§  
§

IN THE DISTRICT COURT OF

TRAVIS COUNTY, TEXAS

53<sup>RD</sup> JUDICIAL DISTRICT

NOTICE OF NON-SUIT UNDER RULE 162

COMES NOW, THE STATE OF TEXAS, Plaintiff in the above-numbered and captioned cause, and represent that it no longer desires to prosecute this cause of action as to Defendant JUAN RICARDO SERRANO and hereby file this Notice of Non-Suit under Rule 162, with prejudice as to refiling, and request that such notice be entered by the clerk in the minutes, and that this cause be removed from the active docket of this court.

SIGNED this the 7<sup>th</sup> day of January, 2011.

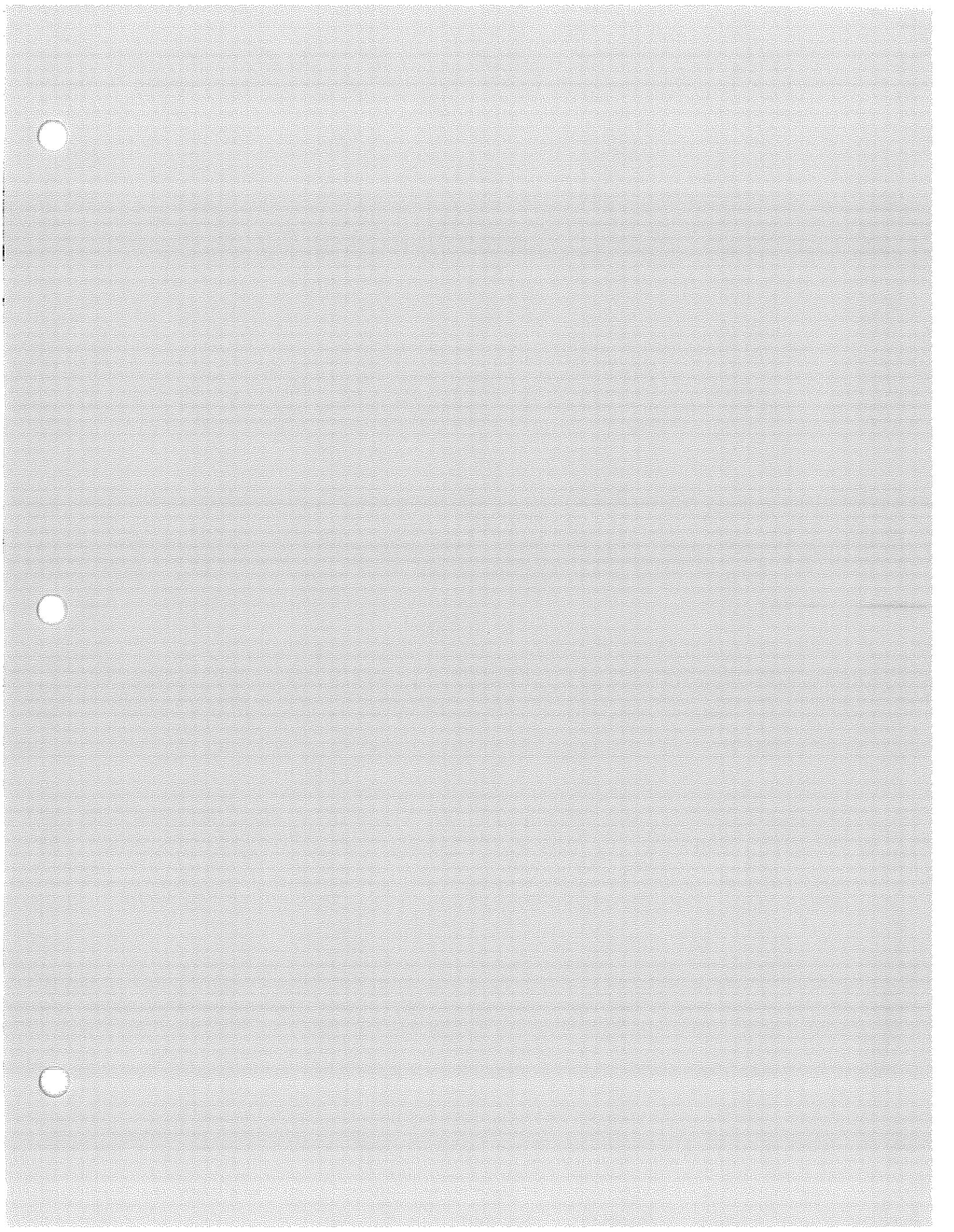
Respectfully submitted,

GREG ABBOTT  
Attorney General of Texas

DANIEL T. HODGE  
First Assistant Attorney General

BILL COBB  
Deputy Attorney General for Civil Litigation

RONALD R. DEL VENTO  
Assistant Attorney General  
Chief, Bankruptcy & Collections Division



Applicant Name (Company) CollabHealth Plan Services, Inc.

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

FEIN: \_\_\_\_\_

**BIOGRAPHICAL AFFIDAVIT**

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

(Print or Type)

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

CollabHealth Plan Services, 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). David Kent Stratton
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. Vice President, Network Strategy and Reimbursement  
Catholic Health Initiatives
4. Affiant's business address. 630 West Wright ~~Street~~ Avenue, 4W Chicago, IL 60614
- Business telephone. (773) 904-7674
5. Education and Training:

<u>College/ University</u>	<u>City/ State</u>	<u>Dates Attended (MM/YY)</u>	<u>Degree Obtained</u>
<u>Springfield College</u>	<u>Springfield, MA</u>	<u>08/1978 - 05/1986</u>	<u>BS and M.Ed.</u>

<u>Graduate Studies:</u>	<u>College/ University</u>	<u>City/ State</u>	<u>Dates Attended (MM/YY)</u>	<u>Degree Obtained</u>
	<u>Yale University School of Medicine</u>	<u>New Haven, CT</u>	<u>8/1993 - 05/1995</u>	<u>M.P.H.</u>

<u>Other Training: Name</u>	<u>City/ State</u>	<u>Dates Attended (MM/YY)</u>	<u>Degree/Certification Obtained</u>
<u>Kellogg Management Institute</u>	<u>Evanston, IL</u>	<u>09/2001 - 05/2002</u>	<u>Non Degree Management Certificate</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.)

Applicant Name (Company) CollabHealth Plan Services, Inc.

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

FEIN: \_\_\_\_\_

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 College of Healthcare Executives		Chicago, IL	(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) 08/2012 - Present Employer's Name Catholic Health Initiatives  
 Address 198 Inverness Avenue West City ~~Denver~~ Englewood State/Province CO  
 Country USA Postal Code 80112 Phone (303) 298-9100 Offices/Positions Held VP, Network Strategy & Reimbursement  
 Supervisor / Contact Juan Serrano

Beginning/Ending Dates (MM/YY) 02/1996 - 08/2011 Employer's Name United Healthcare  
 Address 1701 Brien Road City Minnetonka State/Province MN  
 Country USA Postal Code 55345 Phone (952) 936-1300 Offices/Positions Held Vice President Healthcare Economics  
 Supervisor / Contact Margy Morley

Beginning/Ending Dates (MM/YY) 07/1989 - 07/1993 Employer's Name Mercy Hospital Center for Health  
 Address 271 Carew Street City Springfield State/Province MA  
 Country USA Postal Code 01104 Phone (413) 748-9000 Offices/Positions Held Director, Cardiac Pulmonary Diagnostics & Rehabilitation  
 Supervisor / Contact Cheryl Chiasson

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 Plan Services, Inc.

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

FEIN: \_\_\_\_\_

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

Applicant Name (Company) CollabHealth Plan Services, Inc.

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

FEIN: \_\_\_\_\_

- 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. None

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.

None  
\_\_\_\_\_  
\_\_\_\_\_

Applicant Name (Company) CollabHealth Plan Services, Inc.

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

FEIN: \_\_\_\_\_

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 15<sup>th</sup> day of October 2012 at 3:45 PM 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.

David K. Stratton  
(Signature of Affiant)

State of IL County of COOK

The foregoing instrument was acknowledged before me this 15 day of OCTOBER 2012 By

DAVID K. STRATTON, and:

who is personally known to me, or

who produced the following identification [REDACTED]

[SEAL]



Fran Fernandez  
Notary Public  
FRAN FERNANDES  
Printed Notary Name  
FEB 20, 2013  
My Commission Expires

Applicant Name (Company) CollabHealth Plan Services, Inc.

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

FEIN: \_\_\_\_\_

**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 Plan Services, Inc.  
198 Inverness Drive West  
Englewood, CO 80112  
Ph: 720-874-1293

- Affiant's Full Name (Initials Not Acceptable). David Kent Stratton
- 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 NA
- Foreign Student ID# (if applicable) NA
- Date of Birth: (MM/DD/YY) [REDACTED] Place of Birth: City Cariboo, ME  
State/Province Maine Country USA
- Name of Affiant's Spouse (if applicable) Joy-Constance Stratton

Applicant Name (Company) CollabHealth Plan Services, Inc.

NAIC No.  
FEIN:

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

<u>Beginning/Ending</u> Dates (MM/YY)	Address	City	State/ Province	Country	Postal Code
12/1999 - Current	[REDACTED]	[REDACTED]	Chicago, IL 60614	USA	60614
01/2008 - Current	[REDACTED]	[REDACTED]	New Buffalo, MI	USA	49117

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 15<sup>th</sup> day of October, 20 12 at 3:45 PM 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 Illinois County of Cook

The foregoing instrument was acknowledged before me this 15 day of OCTOBER 20 12 By DAVID K. STRATTON, and:

- who is personally known to me, or [REDACTED]
- who produced the following identification: DAVID K. STRATTON

[SEAL]



[Signature]  
 Notary Public  
FRAN FERNANDES  
 Printed Notary Name  
FEB 20, 2013  
 My Commission Expires

Applicant Name (Company) CollabHealth Plan Services, Inc.

NAIC No.  
FEIN:

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

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

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

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.

David Kent Stratton Chicago, IL 60614  
(Printed Full Name and Residence Address)  
[Signature] 10/15/2012  
(Signature) (Date)

State of IL County of COOK

The foregoing instrument was acknowledged before me this 15 day of OCTOBER 20 12 By DAVID K. STRATTON, and

who is personally known to me, or

who produced the following identification [Redacted]

[SEAL]



[Signature]  
Notary Public  
FRAN. FERNANDES  
Printed Notary Name  
FEB 20, 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). Linda Hope DuPuis
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. Attorney
4. Affiant's business address. Catholic Health Initiatives, 198 Inverness Drive West, Englewood, CO 80112  
Business telephone. 720-874-1154
5. Education and Training:

<u>College/ University</u>	<u>City/ State</u>	<u>Dates Attended (MM/YY)</u>	<u>Degree Obtained</u>	
Miami-Dade Community College	Miami, Florida	01/74-12/75	AA with Honors	
University of Florida	Gainesville Florida	01/76-08/78	BHS	
<u>Graduate Studies:</u>	<u>College/ University</u>	<u>City/ State</u>	<u>Dates Attended (MM/YY)</u>	<u>Degree Obtained</u>
<u>Law</u>	<u>University of Florida</u>	<u>Gainesville, FL</u>	<u>08/92-05/95</u>	<u>JD with Honors</u>
<u>LLM Tax</u>	<u>University of Florida</u>	<u>Gainesville, FL</u>	<u>08/97-08/98</u>	<u>Master of Laws Taxation</u>

<u>Other Training: Name</u>	<u>City/ State</u>	<u>Dates Attended (MM/YY)</u>	<u>Degree/Certification Obtained</u>
<u>Board Certified Health Law</u>	<u>Tallahassee, FL</u>	<u>Exam</u>	<u>08/08</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 Membership Services</u>	<u>Address of Society/Association</u>	<u>Telephone Number of Society/Association</u>
<u>Florida Bar #0056464</u>		<u>The Florida Bar 651 East Jefferson Street Tallahassee, FL 3299-2300</u>	<u>850-561-5600 memberaddress@floridabar.org</u>
<u>Colorado Bar Reg # 43324</u>	<u>Colorado Bar Association</u>	<u>1900 Grant Street, Suite 900 Denver, CO 80203-4336</u>	<u>303-860-1115 800-332-6736</u>
<u>American Health Lawyers #148015</u>	<u>Member Services</u>	<u>1620 Eye Street, 6<sup>th</sup> Floor Washington DC, 20006-4010</u>	<u>202-833-1100</u>

7. Present or proposed position with the applicant entity. Secretary of the Corporation

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) 04/14/11 Employer's Name Catholic Health Initiatives

Address 198 Inverness Drive West City Englewood State/Province Colorado

Country US Postal Code 80112 Phone 303-298-9100 Offices/Positions Held Corporate Counsel

Supervisor / Contact \_\_\_ David Anderson, Esq. 720-874-1308

Beginning/Ending

Dates (MM/YY) -08/08 - 04/11 Employer's Name WellCare Health Plans

Address 8735 Henderson Rd City Tampa State/Province Florida

Country USA Postal Code 33634 Phone 813-290-6200 Offices/Positions Held Senior Corporate Counsel

Supervisor / Contact Steven Jones, Esq., Legal Department

Beginning/Ending

Dates (MM/YY) 02/07- 08/08 Employer's Name Akerman Senterfitt

Address 401 East Jackson Street City Tampa State/Province Florida

Country USA Postal Code 33602-5250 Phone 813-223-7333 Offices/Positions Held Of Counsel

Supervisor / Contact \_\_\_ Joseph Rugg, Esq.

Beginning/Ending

Dates (MM/YY) 07/05-02/07 Employer's Name University Community Health

Address 3100 East Fletcher Avenue City Tampa State/Province Florida

Country USA Postal Code 33613 Phone 813-615-7217 Offices/Positions Held Senior Counsel

Supervisor / Contact Joline Miceli-Mullen

**See attached Schedule A for More Information**

*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

License to Practice Law

Organization/Issuer of License Florida Bar Address 651 East Jefferson Street,

City Tallahassee State/Province Florida Country USA Postal Code 32399-2300

License Type Florida Bar License # 0056464 Date Issued 09/95

Date Expired (MM/YY) CURRENT Reason for Termination \_\_\_\_\_

Non-insurance Regulatory Phone Number (if known) 850-561-5600

Organization /Issuer of License Colorado Bar Address 1900 Grant Street, Suite 900

City Denver State/Province Colorado Country USA Postal Code 80203-4336

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

Date Expired (MM/YY) CURRENT Reason for Termination \_\_\_\_\_

Non-insurance Regulatory Phone Number (if known) 303-860-1115

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? YES. I received probation in 1973 for possession of marijuana and drunkenness. I am in the process of expunging this from my record.

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses? YES. See above. In a separate incident 28 years ago, I was charged with DUI, refusal to sign the citation and refusal to take the breathalyzer test. I was acquitted of the DUI and the other two charges were dismissed.

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

**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? See above answers.
- 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. None

- 
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. None

---

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? Not to my knowledge
- 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)? Not to my knowledge
- 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? Not to my knowledge

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 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.

Linda H. Dupuis  
(Signature of Affiant)

State of Colorado County of Arapahoe

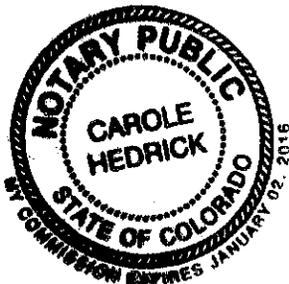
The foregoing instrument was acknowledged before me this 17th day of Dec., 2012 By

Linda H. Dupuis, 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

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>
<u>05/11 Current</u>	<u>6414 Silver mesa Drive Unit B</u>	<u>Highlands Ranch</u>	<u>CO USA</u>	<u>USA</u>	<u>80130</u>
<u>10/05-05/11</u>	<u>13411 Fawn Springs Drive Unit B</u>	<u>Tampa</u>	<u>FL USA</u>	<u>USA</u>	<u>33626</u>
<u>06/05-10/05</u>	<u>9291 Telfer Run</u>	<u>Orlando</u>	<u>FL USA</u>	<u>USA</u>	<u>32817</u>
<u>12/04-06/05</u>	<u>584 Brantley Terrace Way</u>	<u>Altamonte Springs</u>	<u>FL USA</u>	<u>USA</u>	<u>32714</u>
<u>10/02-12/04</u>	<u>15920 Farringham Dr.</u>	<u>Tampa</u>	<u>FL USA</u>	<u>USA</u>	<u>33647</u>

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 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.

[Signature]  
(Signature of Affiant)

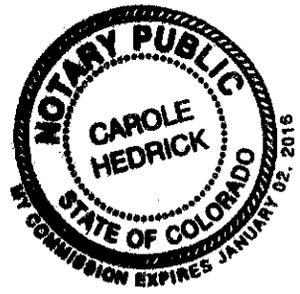
State of Colorado County of Arapahoe

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

Hinda H. Dupuis, and:

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

[SEAL]



[Signature]  
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

**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 Drive West, Englewood, CO 80112  
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.  
Linda DuPuis, 6414 Silver Mesa Drive, Unit B, Highlands Ranch, Colorado 80130

Linda H. DuPuis  
(Signature)

12-17-12  
(Date)

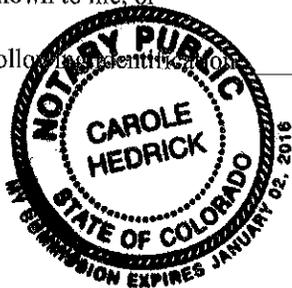
State of CO County of Arapahoe

The foregoing instrument was acknowledged before me this 17th day of Dec. 20 12 By Linda H. DuPuis, 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.Inc.

NAIC No.

FEIN: 46-1222808

SCHEDULE A TO BIOGRAPHICAL AFFIDAVIT  
LINDA HOPE DUPUIS

#8 Employment

Beginning/Ending

Dates: (MM/YY) 12/04-07/05 - Employer's Name Tandem Health Care  
Address 800 Concourse Parkway S., Suite 200 City Maitland State/Province Florida  
Country USA Postal Code 32751 Phone 407-571-1550 Offices/Positions Held Senior Counsel  
Supervisor / Contact Rosemary Corsetti, Esq.

Dates; (MM/YY) 07/02- 12/04 Employer's Name University Community Health  
Address 3100 East Fletcher Avenue City Tampa State/Province Florida  
Country USA Postal Code 33613 Phone 813-615-7217 Offices/Positions Held Senior Counsel  
Supervisor / Contact Joline Miceli-Mullen

**[NOTE: I was rehired at UCH, so worked at the same company twice]**

Dates; (MM/YY) 09/00- 07/02 Employer's Name Kalish & Ward  
Address 101 East Kennedy Blvd, 4100 City Tampa State/Province Florida  
Country USA Postal Code 33602 Phone 813-222-8700 Offices/Positions Held Associate  
Supervisor / Contact William Kalish, Esq.

Dates; (MM/YY) 10/99-09/00 Employer's Name Rogers & Towers  
Address 1301 Riverplace Blvd City Jacksonville State/Province Florida  
Country USA Postal Code 32207 Phone 904-398-3911 Offices/Positions Held Associate  
Supervisor / Contact E. Allen Hieb, Esq.

Dates; (MM/YY) 09/98-10/99 Employer's Name LeBoeuf Lamb Greene & Macrae  
Address 50 North Laura Street, Suite 2800 City Jacksonville State/Province Florida  
Country USA Postal Code 32202 Phone 904-354-8000 Offices/Positions Held Associate  
Supervisor / Contact Not Required

At the University of Florida in the Tax Program 8/97-8/98 See Affidavit

Dates; (MM/YY) 07/95-8/97 Employer's Name Barnett Bolt Kirkwood & Long  
Address 601 Bayshore Blvd City Tampa State/Province Florida  
Country USA Postal Code 33606 Phone 813-253-2020 Offices/Positions Held Associate  
Supervisor / Contact Not Required

At the University of Florida in the Law Program 08/92-05/95 See Affidavit

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). JAMES OTTIS DEAN SWINDE
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. HEALTHCARE EXECUTIVE
4. Affiant's business address. 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112  
Business telephone. 303 383 2708
5. Education and Training:

College/ University	City/ State	Dates Attended (MM/YY)	Degree Obtained
<u>MILLSAP COLLEGE</u>	<u>JACKSON, MS</u>	<u>05/83</u>	<u>BBA ACCOUNTING</u>

Graduate Studies:	College/ University	City/ State	Dates Attended (MM/YY)	Degree Obtained
	<u>DUKE UNIVERSITY</u>	<u>DURHAM, NC</u>	<u>10/2003</u>	<u>MBA</u>

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>
N/A			

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) 05/10 - PRESENT Employer's Name CATHOLIC HEALTH INITIATIVE  
 Address 198 SAVANNAH DR City ENGLEWOOD State/Province CO  
 Country USA Postal Code 80112 Phone 303 383 2708 Offices/Positions Held EVP / CFO  
 Supervisor / Contact KEVIN LITTON, CEO

Beginning/Ending Dates (MM/YY) 08/98 - 07/10 Employer's Name HOVAT HEALTH  
 Address \_\_\_\_\_ City WINSTON SALEM State/Province NC  
 Country USA Postal Code \_\_\_\_\_ Phone \_\_\_\_\_ Offices/Positions Held EVP / CFO  
 Supervisor / Contact PAUL WELLS, CEO

Beginning/Ending Dates (MM/YY) 01/90 - 02/98 Employer's Name GENERAL HEALTH SYSTEM  
 Address \_\_\_\_\_ City BIRMINGHAM State/Province LA  
 Country USA Postal Code \_\_\_\_\_ Phone \_\_\_\_\_ Offices/Positions Held VP - Financial Services  
 Supervisor / Contact PEGGY SCOTT - CFO

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? 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

N/A

Organization/Issuer of License \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_ Country \_\_\_\_\_ Postal Code \_\_\_\_\_

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

Date Expired (MM/YY) \_\_\_\_\_ Reason for Termination \_\_\_\_\_

Non-insurance Regulatory Phone Number (if known) \_\_\_\_\_

Organization /Issuer of License \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_ Country \_\_\_\_\_ Postal Code \_\_\_\_\_

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

Date Expired (MM/YY) \_\_\_\_\_ Reason for Termination \_\_\_\_\_

Non-insurance Regulatory Phone Number (if known) \_\_\_\_\_

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

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.

NO

- 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. \_\_\_\_\_  
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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 20<sup>th</sup> day of December 2012 at \_\_\_\_\_ I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

[Signature]  
(Signature of Affiant)

State of COLORADO County of Arapahoe

The foregoing instrument was acknowledged before me this 20<sup>th</sup> day of Dec., 2012 By

James Dean Swindle and:

who is personally known to me, or

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

[SEAL]

[Signature]  
Notary Public  
Kerry S. Harris  
Printed Notary Name  
1/20/16  
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). JAMES OTIS DEAN STADLE
- Have you ever used any other name including nickname, maiden name or aliases? \_\_\_\_\_ 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>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.

- 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 McComb  
State/Province MS Country USA
- Name of Affiant's Spouse (if applicable) N/A

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
05/10	[REDACTED]	[REDACTED]	DENVER CO	USA	80218
10/02	[REDACTED]	[REDACTED]	WESTON SALEM NC	USA	27104

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

[Signature]  
(Signature of Affiant)

State of COLORADO County of Arapahoe

The foregoing instrument was acknowledged before me this 20th day of Dec, 2012 By

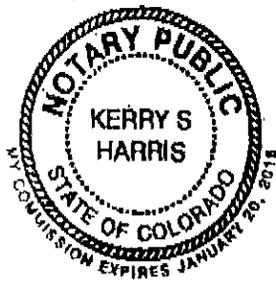
James Dean Swindke and:

who is personally known to me, or

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

[SEAL]

[Signature]  
Notary Public  
Kerry S Harris  
Printed Notary Name  
1/20/16  
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.

JAMES DEAN SWINDLE DENVER, CO 80218  
(Printed Full Name and Res. Address)  
[Signature] 12/20/12  
(Signature) (Date)

State of COLORADO County of Arapahoe

The foregoing instrument was acknowledged before me this 20th day of Dec 2012 By James Dean Swindle and

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

[SEAL]



[Signature]  
Notary Public  
Kerry Harris  
Printed Notary Name  
1/20/16  
My Commission Expires