



**STATE OF SOUTH CAROLINA  
DEPARTMENT OF CONSUMER AFFAIRS**

**DISCOUNT MEDICAL PLAN ORGANIZATIONS**

**Mailing Address**  
P.O. Box 5757  
Columbia, SC 29250-5246

S.C. Code Ann. § 37-17-10 et seq.  
[www.sccconsumer.gov](http://www.sccconsumer.gov)  
(803) 734-4200

**Street Address**  
2221 Devine St. Suite 200  
Columbia, SC 29205

**Discount Medical Plan Organization  
Authorized Representative List**

(Please type or print in black ink)

Please provide the information requested below for ALL representatives authorized to market your discount medical plans. If additional space is needed, use additional copies of page 5, or provide the same information requested below in a self-generated report **The South Carolina Freedom of Information Act may require the Department of Consumer Affairs to release this form as a public record; however personal identifying information will be released only if required by law.**

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**AFFIDAVIT OF APPLICANT**

I swear or affirm and certify that I have completed and/or reviewed all information on this form, and to the best of my knowledge and belief, all information contained herein is true, correct and complete; and that there are no material omissions of fact which would have a bearing upon the South Carolina Department of Consumer Affairs' decision to grant the requested registration certificate. I further certify that I understand that giving false information constitutes cause for denial or revocation of the application and subjects me to criminal prosecution for perjury. I acknowledge that I have a duty and agree to update and correct this information as it changes.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Type or Print your name and Title

SWORN TO AND SUBSCRIBED before me

this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

\_\_\_\_\_

(SEAL)

Notary Public For \_\_\_\_\_

My Commission Expires:

\_\_\_\_\_