State of California
Health and Human Services Agency
Department of Managed Health Care
ELECTRONIC FILING SIGNATURE VERIFICATION
DMHC 10-0066 Rev: 05/19



ELECTRONIC FILING SIGNATURE VERIFICATION

Original hardcopy MUST be returned to: Department of Managed Health Care ATTN: Office of Plan Licensing

980 9th Street, Suite 500 Sacramento, CA 95814

1.0 IDENTIFICATION OF PARTIES

This agreement is between the State of California, Department of Managed Health Care (DMHC) and California Health Care Service Plans, hereinafter referred to as "HCSP".

Health Care Service Plan (HCSP) INFORMATION			
HCSP Name (legal)		HCSP License Number	
		933-	
DBA (if applicable)			
Address (number, street)	City	State ZIP Code	
SIGNATORY INFORMATION			
Name (First, Last)	Pł	none Number	
Title	Er	mail	
REQUESTED ACTION:			
REQUESTED ACTION.			
Signatory Contact			
(for Electronic Execution of eFile)			

SIGNATURE

Signature of Individual (original required, *use blue ink*)

Date

The undersigned, being fully authorized to execute on behalf of the above identified health care service plan, hereby certifies under penalty of perjury pursuant to the laws of the State of California as to this Electronic Filing Signature Verification and any other electronically submitted application, amendment, material modification, or other required filing and each

exhibit and attachment thereto, that the undersigned knows the contents thereof and that the statements therein are true and correct. The undersigned agrees that all future documents filed electronically with the Department of Managed Health Care pursuant to this verification which include the typed name of the undersigned will have the same force and effect as if the undersigned had signed the document by hand and subject to this certification under penalty of perjury.

Authorized by (must be Signatory on file with DMHC for this Plan)	
SIGNATURE	Date

PRINT NAME