State of California
Health and Human Services Agency
Department of Managed Health Care
NOTICE OF EAP EXEMPTION FORM
DMHC 10-112 Rev: 01/19

NOTICE OF EMPLOYEE ASSISTANCE PROGRAM
EXEMPTION RULE 1300.43.14
KNOX-KEENE HEALTH CARE SERVICE PLAN ACT

☐ Original Notice ☐ Amendment to Notice Dated: _____
Amendment date, month and year

The person/entity named in Item 1 below files this notice/amended notice claiming the exemption pursuant to Rule 1300.43.14 under the Knox-Keene Health Care Service Plan Act:

1. Legal Name of Person or Entity filing this notice: _____
Full Name, First Middle and Last Name or Entity

2. Address of principal office:

_____
Street Address or PO Box Number

_____
City, State and Zip Code

Mailing Address, if different:

_____
Street Address or PO Box Number

_____
City, State and Zip Code

3. Fictitious name(s) used in connection with the operation of employee assistance programs:

Fictitious Name (dba): _____
If none, specify "N/A"

Fictitious Name (dba): _____
If none, specify "N/A"

4. Identify each location at which the plan maintains records subject to inspection by the Director under Rule 1300.43.14(a)(6) (if space is insufficient, continue on separate sheet):

Mailing Address: _____
Street Address or PO Box Number

_____
City, State and Zip Code

Mailing Address: _____

Street Address or PO Box Number

_____

City, State and Zip Code

5. Name, title, address and telephone number of representative who may be contacted concerning this notice:

Contacts Name: _____

Contacts Full Name – First, Middle and Last Names

Contacts Title: _____

Title

Mailing Address: _____

Street Address or PO Box Number

_____

City, State and Zip Code

Phone Number: _____

Include Area Code

6. The person/entity filing this notice declares hereby that it is in compliance with the provisions of Rule 1300.43.14, and undertakes to amend this notice within 30 calendar days of any material change in the information specified in its current notice as filed with the Director of the Department of Managed Care.

Date of Notice: _____

Name of Person/Entity Filing Notice: _____

Full Name – First, Middle and Last Names or Entity

Signed By: _____

Print or Type Full Name – First, Middle and Last Names

Title: _____

I certify (or declare) under penalty of perjury under the laws of the State of California that I have read this Notice and its attachments thereto and know the contents thereof and that the statements therein are true and correct.

Executed at: _____ _____

City and State *Today's Date – Month Day, Year*

_____

Signature