## PROFESSIONAL EMPLOYER ORGANIZATION -NOT LICENSED THROUGH AN ASSURANCE ORGANIZATION LICENSE APPLICATION

	<b>Initial Application</b>		<b>Renewal Application</b>
_	4.4	_	1.1

Legal name of applicant:			FEIN#:_		
List any other names under whic Applicable".	h the PEO will enga			. If there are no other names, e	enter "Not
Principal business location:	Street City, State, ZIP				<del>_</del>
Mailing address, if different from	n principal business	location. If ther	e is none, enter "Non	e"	
	Street City, State, ZIP				_ _
Business location of each Utah of	office (street, city, st	tate, ZIP code), p	lease provide on attac	chment: Attachment	
Contact person (name, title, telep Title P	phone number, fax r	number, email ad Fax	dress): Name Ema	ail	
Applicant's Website Address. If	f the company does	not have one, ent	ter "None" Site		
Has there been any adverse regu PEO, an owner, a director, an of If yes, attach an explanation and	ficer, or senior exec	utive officer?	Yes No	enforcement or regulatory agen  Attachment	
professional employer organization not qualify as a group and must a	No he professional empton group under this apply as an individuntity of the professions chapter? Yes	Not Applicable bloyer organizations chapter? Yes all Professional Econal employer or No If "no	e If yes: on group guarantee th No If "no" th Employer Organizatio ganization group gua " the Professional En	ne obligations of each other me ne Professional Employer Orga n. rantee the obligations of the pro-	ember of the anization does rofessional
The following information 1.Payment of a non-refundable \$					
2.A copy of the applicant's article previous application, mark "no control of the application, mark are control of the applicant's article previous application, mark are control of the applicant's article previous application, mark are control of the applicant's article previous application, mark are control of the applicant are cont		or other business		ents. If there has been no chan Attachment	ige since
3. A list by jurisdiction of each rames of predecessors and, if kn  None	own, successor busi	iness name. If th		ange, mark "None" or "No Cha	
4. A list of applicant's Utah clie	nts.	Attachment _			
5. Documentation that demonstration a. has at least \$100,000 in words. provide one of the following i. a bond;	king capital as deter in an amount equal	rmined by genera	lly accepted accounti	ng principles; or	apital:

- ii. an irrevocable letter of credit;
- iii. one or more credits or securities as determined by the market value of the credits or securities, or;
- iv. a combination of i through iii above.

<ul> <li>6. A copy of the applicant's most recent financia.</li> <li>a. is prepared on a GAAP basis:</li> <li>b. is audited by an independent CPA,</li> <li>c. complies with Section 31A-40-205; and</li> <li>d. complies with Section 31A-40-305.</li> </ul>	al statement that:	Attachment _	
7. A statement of ownership that: a. includes the name of a person that, individual indirectly, 10% or more equity interest in the PI b. includes a completed Biographical Affidavi change since previous application was filed, materials.	EO; and t, found on the Depa	rtment's Web site, for each	named person. If there has been no
8. A list of all individuals who serve as a direct completed Biographical Affidavit, found on the since previous application was filed, mark "No	Departments Web S	Site, for each individual on the	
<ul><li>9. Documentation explaining how the applicant documentation must include. Please include into a. the name of the insurer providing workers'</li><li>b. if a client is self-insured, a copy of the approximation.</li></ul>	formation for all cov compensation insura	erage provided: ance for each client; or	Attachment
10. Documentation explaining how the applicar 31A-40-210. Please include information for all			
11. Documentation on health benefit plans, if of provide any health coverage, mark "None":  a. for a fully insured health benefit plan: i. the name of the insurance company issuing ii. the term and effective date of coverage. b. for a not fully insured health benefit plan pri. the PEO operated as a PEO for at least one yii. the health benefit plan is administered by a iii. all assets of the health benefit plan, including iv. the health benefit plan has and maintains regenerally accepted actuarial standards of practic v. the health benefit plan provides written notinglan is self-insured or is not fully insured; and vi. the health plan consents to an audit, to be p finding of reasonable need by the commissioner	None the health benefit please to a covered emplored with the control of t	he health benefit plan; rator licensed to do business butions, are held in a trust and for the health benefit plan dent qualified actuary; loyee participating in the health	chment  in this state; ccount; as determined by an actuary who uses alth benefit plan that the health benefit
I hereby certify that, under penalty of perjury, a complete. I am aware that submitting false info application is grounds for license revocation or	ormation or omitting	pertinent or other material is	nformation in connection with this
I further certify that I grant permission to the Cocurrent or former employer, or insurance compa		y information with any fede	ral, state, or local government agency,
Signature Date	Printed Name		Title
Submitting this application and attachments the	reto certifies that the	statements and documentat	ion are true.

July 8, 2015 Revision