EXHIBIT A DATE:_____

APPLICATION
FOR REGISTRATION OF
JOINT PUBLIC AGENCY SELF-FUNDED HEALTH CARE PLAN

_____
Name of Joint Public Agency and Trust ("JPA")

_____
Principal Office of JPA Address and Phone No.

Proposed Effective date of the Plan:_____

TO THE DIRECTOR OF INSURANCE OF THE STATE OF IDAHO:

STATE OF)
) ss
COUNTY OF _____)

_____ and _____,
Trustee(s), being duly sworn each for himself or herself deposes and says that the information contained in this Application for Registration (inclusive of Exhibits as appended to the Application) is true to the best of his or her information, knowledge and belief.

_____
Member, Board of Trustees

_____
Member, Board of Trustees

SUBSCRIBED AND SWORN TO BEFORE me the undersigned NOTARY PUBLIC OF IDAHO, this _____day of_____, 20____.

_____
NOTARY PUBLIC OF IDAHO
My Commission Expires:_____

REGISTRATION

GENERAL INTERROGATORIES

1. Is this JPA Plan maintained for the purpose of complying with any workers' compensation law or unemployment compensation disability insurance law?

   _____

2. Is this JPA Plan primarily for the purpose of providing first aid care and treatment, at a dispensary of the employer, for injury or sickness of employees while engaged in their employment?_____. (If yes, please describe below).

   _____

   _____

3. Has this JPA Plan been in existence and in operation prior to submission of this Application to the Idaho Department of Insurance?_____. If yes, provide the effective date of initial operation:_____.

4. Give the complete names and addresses of the members(s) of the JPA Plan and Trust for whose employee-beneficiaries the trust fund will be, or is, operated:

   _____

   _____

   _____

   _____

   _____

   _____

5. Give the complete name, address, and contact information of every trustee(s) of the JPA Plan and Trust:

   _____

   _____

   _____

   _____

6. Give the complete name, address, and contact information of the administrator of the JPA Plan and Trust.

_____

_____

_____

7. Give the complete name(s), address, and contact information of any consultant employed by, and/or contracted with, the JPA Plan and Trust.

_____

_____

_____

8. Give the complete name(s), address, and contact information of insurance producers, if any, including agents or brokers transacting business with the JPA Plan and Trust, if any.

_____

_____

_____

9. Give the complete name(s), address, and contact information of any associated or affiliated plans and/or trust funds under the management, control, or operation of the administrator or trustees named above.

_____

_____

_____

_____

10. If benefits are currently or to be provided by any means other than direct payments of benefits out of a trust; please complete the following schedule and attach a copy of the group policy and/or other contract covering these benefits:

General Description of Benefit:	Name & Address of Person Providing Benefits:

_____

_____

_____

_____

_____

11. Are all contributions to the JPA Plan and Trust currently, or are to be, payable in advance?_____

12. Does the JPA Plan operate under the provisions of a Trust Agreement between the JPA members and the Trustee?_____. **If so, please attach a copy of the Trust Agreement.**

13. Does the JPA Plan have bylaws of any kind?_____. **If so, please attach a copy of any bylaws.**

14. Have instructions, guidelines, or rules, including the requirements for trustee fiduciary duties, been established for trustees and administrators of the JPA Plan? _____. **If so, please provide a copy of such instructions, guidelines, or rules.**

15. If the JPA Plan and Trust is currently in operation or is planned to be in operation in the future, have each and every employee-beneficiaries of the members of the JPA Plan and Trust received, or will each future employee-beneficiary receive, a written statement or schedule adequately and clearly stating all benefits allowable under the JPA Plan, together with all applicable restrictions, limitations and exclusions, and the procedure for filing a claim for benefits?_____. **Please provide a copy of such a plan or written benefit statement.**

16. If the JPA Plan and Trust is currently in operation, how often is the Trust Fund audited by an independent accountant?_____

    Please provide the name and address of auditing firm:

    _____

    _____

    Please attach the most recent copy of any such audit.

17. (a) Have all individuals that will handle receipts and disbursements for the JPA Trust Fund been bonded under a fidelity bond issued by a Surety authorized to transact such surety business in the State of Idaho, pursuant to Idaho Code §41-4114(3) and IDAPA 18.01.28.027?_____

    If so, give name and address of the Surety_____

    _____

    and the amount of fidelity coverage: _____

(b) Are individuals handling receipts and disbursement for the Trust Fund licensed as third party administrators in accordance with title 41, chapter 41, Idaho Code? If so, please identify the name(s), address, and contact information of such licensees.

_____

_____

_____

(c) Are administrators that administer the JPA Plan and Trust properly licensed under title 41, chapter 9, Idaho Code, and propertly bonded in accordance with section Idaho Code §41-911(8)?_____

18. Has the JPA Plan and Trust engaged an actuary to determine rates and claims reserves, including IBNR, pursuant to Idaho Code §§ 41-4105(2)(f) and 41-4110, and IDAPA 18.01.28.026?_____

    If so, please give the complete name, address, and contact information of the qualified actuary:_____

19. Does the JPA Plan and Trust have competent and trustworthy accountants to timely prepare monthly and quarterly financial statements for the Plan? If so, give the complete name, address, and contact information of said accountant(s):

    _____

    _____

20. Please complete the attached chart on page 6.

	BENEFITS CHECKED ARE PROVIDED				CONTRIBUTIONS ARE MADE BY		APPROX. NUMBER OF BENEFICIARIES COVERED	
Benefit	Directly Out of Trust Fund	By Insurance Carrier(s)	By Hospital and Medical Serv. Plans	Other (Specify)	Employer	Employee Payroll Deduction	Employee	Covered Deps.
Disability Income								
Hospital								
Medical								
Surgical								
Dental								
Vision Services								
Other (Specify)								