Reset

ARIZONA DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS

LIFE CARE PROVIDER ANNUAL REPORT AMENDMENT

FOR THE FISCAL YEAR ENDING: _____

AMENDMENT DATE: _____

_____
(Full and Exact Corporate Name)

_____ OF:
(Doing Business As / Or Facility Name)

_____
(Statutory Home Office Address: Street & Number, City, State, Zip Code and phone number)

_____
(Administrative Office Address: Street & Number, P.O. Box, City, State, Zip Code – enter phone numbers below)

Phone No.: _____ Toll-Free: _____ Fax No.: _____

NAIC No.(if assigned): _____ Fed. ID No.: _____

organized under the laws of _____ on _____
(Month, Day, Year)

as a ☐ Non-Profit Corporation ☐ Stock Company ☐ Partnership

☐ Other (Specify): _____

hereby submits the attached information and Exhibits in accordance with ARS § 20-1807.

Dated at _____ , this _____ day of _____ , 20 _____

I hereby depose and certify that I have prepared or reviewed this Report and it is true, complete, and correct to the best of my knowledge and belief.

_____ _____
Signature of Chief Executive Officer ONLY Chief Executive Officer's Name and Title

Subscribed and sworn to before me, this _____ day of _____ , 20 _____

_____ _____
Notary Signature My Commission Expires

Stamp or Seal here

_____ _____
Preparer's Name and Title Preparer's Phone Number and E-Mail Address

THERE IS NO FILING FEE REQUIRED FOR THIS ANNUAL REPORT AMENDMENT.

Send the document to financialfilings@difi.az.gov.

E-LIFECARE.AMEND (v 20201031)