

Conflict of Interest Form

Instructions

- Please answer every question. If a question does not apply, mark N/A.
- Where “Yes,” provide full details in the comment field or attach supporting documents.
- Authorized representative must sign the attestation at the end.
- For purposes of this disclosure, affiliated person(s) include:
 - Any individual within your organization (including employees, officers, directors, board members, or managing agents) and their spouse, domestic partner, child, parent, or sibling
 - Any corporation or organization in which you or any person employed by your organization:
 - Serves as a board member, officer, partner, manager, or employee
 - Holds, directly or indirectly, any debt interest or is the beneficial owner of any class of equity securities
 - Any trust or other estate in which you or any person employed by your organization has a substantial beneficial interest or serves as a trustee or in a similar fiduciary capacity

Section 1: Vendor Information

- **Vendor Name:**
- **Tax ID Number:**

Section 2: Financial Interests & Relationships with Health Plan of San Joaquin/Mountain Valley Health Plan (Health Plan)

1. Does any person connected with your organization (owners, officers, directors, key employees) have a substantial financial interest in Health Plan or its commissioners/workforce (including immediate family)?
 Yes No
If yes, describe the interest and mitigation steps.

2. Is any of your staff currently employed by Health Plan (or its related entities) in a role that participates in selection, award, or administration of this contract? Yes No
If yes, identify the person(s) and role(s). (COI standards prohibit participation where personal interests exist.)

Section 3: Organizational Conflicts of Interest (OCI)

1. Is your organization part of a parent/affiliate/subsidiary structure that provides services to Health Plan or competitors that could bias this engagement? Yes No
If yes, describe the relationship(s) and potential OCI, plus safeguards (firewalls, separate teams, recusal protocols).

Section 4: Transactions and Other Relationships with Health Plan

1. Have you or any affiliated person(s) provided services or property to Health Plan in the past year?
 Yes No
If yes, describe the provided services or property and identify the affiliated persons(s) and relationship.
2. Have you or any affiliated person(s) purchased services or property from Health Plan in the past year?
 Yes No
If yes, describe the purchased services or property and identify the affiliated person(s) and relationship.
3. Did you or any affiliated person(s) have any direct or indirect interest in any business transaction(s) (financial and/or ownership) in the past year to which Health Plan was or is a party? Yes No
If yes, describe the transaction(s) and identify the affiliated person(s) and relationship.
4. Were you or any affiliated person(s) indebted to pay money to Health Plan at any time in the past year (other than travel advances or similar items)? Yes No
If yes, describe the indebtedness and identify the affiliated person(s) and relationship.
5. In the past year, did you or any affiliated person(s) receive, or become entitled to receive, directly or indirectly, any personal benefits from Health Plan of San Joaquin or as a result of your relationship with Health Plan, that in the aggregate could be valued in excess of \$1,000, that were not or will not be compensation directly related to your duties? Yes No
If yes, describe the benefit(s) and identify the affiliated person(s) and relationship.

6. Are you or any affiliated person(s) a party to or have an interest in any pending legal proceedings involving Health Plan? Yes No

If yes, describe the proceeding(s) and identify the affiliated person(s) and relationship.

7. Are you aware of any other events, transactions, arrangements, or situations that have occurred or may occur in the future that you believe should be examined by Health Plan's Compliance Officer in accordance with the terms and intent of Health Plan's conflict of interest policy? Yes No

If yes, describe the situation(s) and identify the affiliated person(s) and relationship.

Section 5: Attestation and Certification

I hereby confirm that I have read and understand this form and that my responses are complete and correct to the best of my knowledge. I agree that if I become aware of any information that might indicate this disclosure is inaccurate or that I have not complied with this form, I will notify Health Plan's Compliance Officer immediately.

Name:

Title:

Signature:

Date:

Note: A blank page is attached if additional space is needed.

Continuation Page – Additional Vendor Responses