The State of New Hampshire
Insurance Department

21 South Fruit Street, Suite 14
Concord, NH 03301

Telephone 603-271-2261 • Fax 603-271-1406 • TDD Access: Relay NH 1-800-735-2964
www.nh.gov/insurance

APPLICATION for REGISTRATION

☐ Initial Application
☐ Renewal Application (All renewal applications must include the PBM Annual Rebate Summary spreadsheet. Pages 2-3 may be disregarded unless there have been changes.)

PHARMACY BENEFITS MANAGER – RSA402-N

PHARMACY BENEFITS MANAGER NAME: _____

TRADE NAME (if any):

DOMICILE: _____

ADDRESS: _____

OTHER NEW HAMPSHIRE LICENSES OR CERTIFICATES OF AUTHORITY (if any):

_____

_____

If PBM has already been granted a Third-Party Administrator certificate of authority disregard page 3.

CONTACT NAME: _____

CONTACT TITLE: _____ PHONE: _____

CONTACT ADDRESS: _____

_____

CONTACT E- MAIL ADDRESS: _____

*Note: This Department will only correspond with the named contact person. This individual may be in the company or a contracted person such as a consultant.

REGISTRATION FEES

Initial Application:	$500.00
Renewal Application:	$100.00

All checks must be made payable to: New Hampshire Insurance Department. **Checks must be mailed WITH** a copy of the first page of the application for identification purposes, to the Financial Regulation Division, Insurance Department,21 South Fruit St., Suite 14, Concord, NH 0330 I.

All renewal applications and PBM Annual Rebate Summary spreadsheets **must be emailed** to Linda M. Zalinskie, Financial Records Auditor at Linda.M.Zalinskie@ins.nh.gov.

Our review process will not begin until ALL fees are paid. New Hampshire law does not allow for the payment of fees after the approval of registration.

NOTICE of CONTRACT

BETWEEN PHARMACY BENEFITS MANAGER AND HEALTH CARRIER

This form must be filled out for each contract the pharmacy benefits manager has with a health carrier.

PBM NAME: _____

TRADE NAME (if used): _____

ADDRESS: _____

_____

NAME of HEALTH CARRIER: _____

ADDRESS: _____

_____

CONTACT NAME: _____

CONTACT TITLE: _____ PHONE: _____

CONTACT ADDRESS: _____

_____

Effective Date of Contract: _____

Location of books and records maintained by the Pharmacy Benefits Manager in regard to this agreement:

_____

_____

_____

(Signature of PBM Representative)

_____

(Printed Name of PBM Representative)

SECTION 1 - MANAGEMENT

BIOGRAPHICAL AFFIDAVITS AND OFFICIAL LIST OF ALL INDIVIDUALS responsible for the conduct of affairs of the Pharmacy Benefits Manager. The NHID accepts the NAIC biographical affidavit. The list should give the name, position occupied, address and the professional qualifications of each of these individuals. It should also be sworn to as a true and complete list by the secretary of the pharmacy benefits manager. The list shall include:

- Board of Directors
- Board of Trustees
- Executive Committee/Governing Board/Committee
- Principal Officers (Partners or members in the case of Partnership, Association or LLC)
- Shareholders (10% or more)
- Others exercising control/influence

SECTION 2 - DOCUMENTARY

1. **CERTIFIED COPIES OF ALL BASIC ORGANIZATIONAL DOCUMENTS**, including Articles of Incorporation, Articles of Association, partnership agreements, trade name certificate, trust agreement, shareholder agreement, recent certificate of good standing for state of domicile and for the State of New Hampshire, and all amendments thereto. These items should be certified by the proper domiciliary state official.
2. **COPY OF THE BY-LAWS** of the applicant certified as a true and correct copy of the secretary of the company.

RECORDS. The location where the books and records maintained by the PBM are located:

_____

_____

The license or authority of the PBM in any state, district or country has at no time been revoked, suspended, or canceled, nor has it been refused admission to any state, district, or country, except as stated below (state in full detail any exception):

_____

_____

_____

_____

_____

_____

AFFIRMATION

I subscribe and affirm, under penalty of perjury, that the statements made in this application, including statements made in accompanying papers, have been examined by me and to the best of my knowledge and belief are true, correct, and complete, and that I am duly authorized to execute this affirmation.

_____
(Authorized Representative - Signature)

_____
(Printed Name)

NOTARIZATION

STATE of _____

COUNTY of _____

This Instrument was acknowledged by me this _____ (date) by

_____ (Name of person signing this document)

(SEAL)

_____
(Notary Public Signature)

_____
(Printed Name)

Commission Expires: _____