

**COMMONWEALTH OF PENNSYLVANIA  
INSURANCE DEPARTMENT**

**Insurance Administrator License  
Corporation or Partnership Application**

**Type or Print - Complete All Necessary Information**

**PART I – IDENTIFICATION**

**NOTE:** A license is required for each unique Employer Identification Number.

<b>Employer Identification Number:</b> -	<b>Entity Type:</b> <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership	<b>Incorporation/Formation Date:</b> (mm/dd/yy)
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**Full Legal Name of Applicant:**

<b>Mailing Address:</b>	Street (Required) (If applicable, include P.O. Box)	
	City	State Zip Code

<b>Business Address:</b> <input type="checkbox"/> Same as mailing address	Street (Required) (If applicable, include P.O. Box)	
	City	State Zip Code

<b>Business Telephone Number:</b> ( ) -	<b>Business Fax Number:</b> ( ) -
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**PART II – LICENSURE ACTIVITIES AND LINES OF BUSINESS**

COMPLETE EACH SECTION BELOW AS IT RELATES TO THE APPLICANT’S ACTIVITIES FOR RESIDENTS OF PENNSYLVANIA. NOTE: A LICENSE IS REQUIRED ONLY IF THERE ARE PENNSYLVANIA RESIDENTS COVERED BY THE PLANS THE APPLICANT ADMINISTERS.

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| <b>CHECK ALL THOSE THAT APPLY:</b>                                 | <b>CHECK ALL THOSE THAT APPLY:</b>                 |
| <input type="checkbox"/> COLLECT CHARGES OR PREMIUMS FOR ANY PLANS | <input type="checkbox"/> LIFE INSURANCE COVERAGE   |
| <input type="checkbox"/> ADJUSTS OR SETTLES CLAIMS FOR ANY PLANS   | <input type="checkbox"/> HEALTH INSURANCE COVERAGE |
|  | <input type="checkbox"/> ANNUITIES                 |

**PART III – TRADING AS NAME**

If the applicant transacts business in Pennsylvania under an assumed trade name, provide the full name in the space provided below. If no assumed trade name is used, leave black.

Trading as Name: \_\_\_\_\_

**PART IV – BACKGROUND INFORMATION**

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	1. HAS THE APPLICANT OR THE OWNERS, OFFICERS, MANAGERS AND/OR PARTNERS OF THE BUSINESS ENTITY EVER BEEN PENALIZED OR FINED, HAD A LICENSE REFUSED, SUSPENDED OR REVOKED BY THE INSURANCE DEPARTMENT OF THIS STATE OR ANY OTHER STATE OR PROVIDENCE OF CANADA? <b>(If yes, provide a full explanation on a separate sheet of paper.)</b>

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	2. HAS THE APPLICANT OR THE OWNERS, OFFICERS, MANAGERS AND/OR PARTNERS OF THE BUSINESS ENTITY EVER BEEN CONVICTED OF OR PLED NOLO CONTENDERE (NO CONTEST) TO ANY MISDEMEANOR OR FELONY OR CURRENTLY HAVE PENDING MISDEMEANOR OR FELONY CHARGES FILED AGAINST THE APPLICANT? (MISDEMEANOR DOES NOT INCLUDE MINOR TRAFFIC VIOLATIONS.) (If yes, give date, name, and address of court, basis, and outcome.)

<b>Officers/Partners</b>	List the following information for all officers of the corporation or partners of the partnership.	
Name	Soc Sec # / EIN	Title
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<i>ATTACH A SEPARATE SHEET LISTING OTHER OFFICERS/PARTNERS IF NECESSARY</i>		

**PART V – FINANCIAL RESPONSIBILITY AND SECURITY INFORMATION**

1. ALL LICENSED ADMINISTRATORS ARE REQUIRED TO MAINTAIN AN ERRORS AND OMISSIONS INSURANCE POLICY. IN THE SPACE BELOW, PLEASE LIST THE DETAILS REGARDING YOUR COVERAGE.

			(mm/dd/yy)
POLICY NUMBER	ISSUING COMPANY	AMOUNT OF COVERAGE/LOC	POLICY EXPIRATION

2. ALL LICENSED ADMINISTRATORS THAT ARE REQUIRED TO MAINTAIN FINANCIAL RESPONSIBILITY, PLEASE LIST THE DETAILS REGARDING YOUR FINANCIAL REQUIREMENTS IN THE SPACE BELOW.

			(mm/dd/yy)
POLICY NUMBER	ISSUING COMPANY	AMOUNT OF COVERAGE/LOC	POLICY EXPIRATION

AVERAGE AMOUNT OF FUNDS HELD BY THE APPLICANT: \_\_\_\_\_ (FOR ALL PLANS)

**PART VI – APPLICANT'S CERTIFICATION**

I do hereby certify under penalty or perjury that the foregoing statements and information are true and correct and that any license issued in consequence hereof shall be contingent upon the truth of these statements. Furthermore, I confirm that I understand fully the insurance laws and regulations of Pennsylvania, regarding insurance administrators, including but not limited to, the requirement for a written agreement between the insurance administrator and the Plan Provider and the fiduciary capacity of the insurance administrator.  
**NOTE:** There are criminal penalties for false statement.

Notary Seal   Subscribed and sworn before me on this _____ day of _____, 20____.  Commission Expires:	_____ Officer/Partner Signature  _____ Officer/Partner Name (print or type)  _____ Officer/Partner Title (print or type)
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