**IDL-56 IA(Corporation or Partnership) (Page 1 of 2)**

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| **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. |
| **Employer Identification Number**:  -      | **Entity Type**:[ ]  Corporation[ ]  Partnership[ ]  LLC | **Incorporation/Formation Date**: (mm/dd/yy)      |
| **Full Legal Name of Applicant**:      |
| **Mailing Address**: |       |
| Street (Required) | (If applicable, include P.O. Box) |  |
|       |    |       |
| City | State | Zip Code |
| **Business Address**:[ ]  Same as mailing address |       |
| Street (Required) | (If applicable, include P.O. Box) |  |
|       |    |       |
| City | **State** | Zip Code |
| **Business Telephone Number**: (   )     -      | **Business Fax Number:****(**   )     -      |
| **Business Email Address:**:      |
| **PART II – LICENSURE ACTIVITIES AND LINES OF BUSINESS** |
| COMPLETE EACH SECTION BELOW AS IT RELATES TO THE APPLICANT’S ACTIVITIES FOR RESIDENTS OF PENNSYLVANIA. IDENTIFY BOTH THE LICENSURE ACTIVITIES APPLICANT INTENDS TO PERFORM AND LINES OF BUSINESS PROPOSED TO BE ADMINISTERED. **CHECK ALL THOSE THAT APPLY:** **CHECK ALL THOSE THAT APPLY:**

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| [ ] COLLECT CHARGES OR PREMIUMS FOR ANY PLANS |  | [ ] LIFE INSURANCE COVERAGE |
| [ ] ADJUSTS OR SETTLES CLAIMS FOR ANY PLANS |  | [ ] HEALTH INSURANCE COVERAGE |
|  |  | [ ] 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 |  |
| [ ]  | [ ]  | 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? **(If yes, provide a full explanation on a separate sheet of paper.)** |

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| **IDL-56 IA (Corporation or Partnership)** | **Page 2 of 2** | **Employer ID No:   -** |
| YES | NO |  |
| [ ]  | [ ]  | 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.)** |
| **Officers/Partners** | List the following information for all officers of the corporation or partners of the partnership. |
|  |       |       |       |
|
| Name | Soc Sec # / EIN  | Title |
|       |       |       |
|
| Name | Soc Sec # / EIN | Title |
|       |       |       |
|
| Name | Soc Sec # / EIN | Title |
|       |       |       |
|
| Name | Soc Sec # / EIN | Title |
| *ATTACH A SEPARATE SHEET LISTING OTHER OFFICERS/PARTNERS IF NECESSARY* |
| **PART V – FINANCIAL RESPONSIBILITY AND SECURITY INFORMATION** |
| 1. ALL LICENSED ADMINISTRATORS ARE REQUIRED TO MAINTAIN AN ERRORS AND OMISSIONS INSURANCE POLICY. PLEASE LIST THE DETAILS REGARDING YOUR COVERAGE IN THE SPACE BELOW.

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|       |  |       |  |       |  |       (mm/dd/yy) |

POLICY NUMBER ISSUING COMPANY AMOUNT OF COVERAGE/LOC POLICY EXPIRATION1. ALL LICENSED ADMINISTRATORS ARE REQUIRED TO MAINTAIN FINANCIAL RESPONSIBILITY IN THE FORM OF A FIDELITY BOND. PLEASE LIST THE DETAILS REGARDING YOUR COVERAGE IN THE SPACE BELOW.

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|       |  |       |  |       |  |       (mm/dd/yy) |

POLICY NUMBER ISSUING COMPANY AMOUNT OF COVERAGE/LOC POLICY EXPIRATION

|  |  |  |
| --- | --- | --- |
| AVERAGE AMOUNT OF FUNDS HELD BY THE APPLICANT:  |       | (FOR ALL PLANS) |
|  |  |  |

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| **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 SealSubscribed and sworn before me on this\_\_\_\_\_\_\_\_\_\_day of \_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SignatureCommission Expires: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Officer/Partner Signature     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Officer/Partner Name (print or type)     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Officer/Partner Title (print or type) |