(Form AL-PL-1)

PRELICENSING PROVIDER APPLICATION

Provider Name: _____

Provider #: _____
For Departmental Use Only

FEIN: ____ - _____

Provider is:
[] Statewide Agents Association
[] Insurance Trade Association
[] Approved Pre-licensing Provider
[] Institution of Higher Learning
[] Bona Fide Education School
[] Other (Describe): _____
[] Authorized Insurer
[] Provider of Independent Program of Instruction

General Information:

Mailing Address: _____
Street or P.O. Box City State Zip

Street Address: _____
(if different) Street City State Zip

Telephone#(s) (____) ____ - _____ (____) ____ - _____ Fax# (____) ____ - _____

Name of Provider Representative (Contact Person): _____
First Name MI Last Name

E-Mail Address: _____

WEB Address: _____

Courses to be offered:

[] P & C [] Life & Health [] Bail Bond

[] Course offered to general public
[] Course offered only to employees of insurance company

_____ Date: _____
Signature of Authorized Prelicensing Provider Representative

Sworn to and subscribed before me this the _____ day of _____, 20_____.

_____ _____
Notary Public Commission Expires

Notary Stamp Here

Mail To:

State of Alabama Department of Insurance
Continuing Education Section
P O Box 303351
Montgomery, AL 36130-3351