STATE OF ALABAMA
DEPARTMENT OF INSURANCE
201 MONROE STREET, SUITE 502
POST OFFICE BOX 303351
MONTGOMERY, ALABAMA 36130-3351
TELEPHONE: (334) 269-3550
FACSIMILE: (334) 241-4192

Pharmacy Benefit Manager (PBM)
Initial Application

sample

Section 1. Applicant Demographic Information:

Exact Legal Name of Applicant:	FEIN/SSN:
DBAs or Other Names Used by Applicant:	
Name of Primary Contact for PBM:	Primary Contact Email:
Primary Contact Title:	Primary Contact Direct Telephone:
Does the PBM hold any other licenses in Alabama? (if yes, list all other license types, attaching additional sheets if necessary)	
Name of PBM's Parent Company (if applicable):	

Applicant's agent for service of process in Alabama:

Name:	Title:
Direct Telephone:	Contact Email:
Mailing Address:	

Information on each person with management or control over the PBM (attach additional sheets if necessary):

Name:	Title:
Direct Telephone:	Contact Email:
Mailing Address:	
Name:	Title:
Direct Telephone:	Contact Email:
Mailing Address:	
Name:	Title:
Direct Telephone:	Contact Email:
Mailing Address:	

Information on each person with a beneficial ownership interest in the PBM (attach additional sheets if necessary):

Name:	FEIN (if applicable):
Direct Telephone:	Contact Email:
Mailing Address:	
Name:	FEIN (if applicable):
Direct Telephone:	Contact Email:
Mailing Address:	

Sample

Name:	FEIN (if applicable):
Direct Telephone:	Contact Email:
Mailing Address:	

Complaint/Appeals Process Contact Information:

Note: all complaints received by the ALDOI against the PBM will be forwarded to this contact for response.

Name of Appeals Contact:	Title:	Direct Telephone:
Mailing Address:	Contact Email:	

sample

Section 2. Organization Structure:

A PBM applicant that is a partnership or other unincorporated association, limited liability company, or corporation must complete the following section:

Specify legal structure of applicant:	
Provide total number of partners, members or stockholders who, directly or indirectly, own, control, hold with the power to vote or hold proxies representing 10% or more of the voting securities of any other person.	
*By submitting this application, the PBM agrees that, upon request by the Department, the PBM will provide information regarding the name, address, usual occupation and professional qualifications of any other partners, members or stockholders who, directly or indirectly, own, control, hold with the power to vote, or hold proxies representing 10% or more of the voting securities of any other person.	

Section 3. Applicant Qualifications:

Attach to the application a full explanation and/or the requested information for questions below. Failure to provide the required information or any omissions may result in the denial of this application.

A. Applicant Background:

1. Has any officer with management or control of the PBM been refused or denied a registration, license or certification to act as (or provide the services of) a PBM or Third-Party Administrator in any state? If yes, attach specific details separately for each such refusal or denial, including the date, nature and disposition of the action.	☐ Yes ☐ No
2. Has the applicant or officer with management or control had any registration, license or certification to act as (or provide the services of) a PBM or Third-Party Administrator suspended, revoked or nonrenewed for any reason by any state or federal entity? If yes, attach specific details separately for each such suspension, revocation or nonrenewal, including the date, nature and disposition of the action, and attach a copy of any relevant final order or similar document imposing the suspension, revocation or nonrenewal.	☐ Yes ☐ No

3. Has the applicant had a relationship with an insurer, other than that of a policyholder, terminated for any fraudulent or illegal activities? If yes, attach specific details separately explaining this termination, including the date, and nature of the termination.	☐ Yes ☐ No
4. Has an officer with management or control of the PBM, been convicted of a felony or violated any of the requirements of state law applicable to Pharmacy Benefit Managers? If yes, attach a signed statement describing the relevant conviction or violation.	☐ Yes ☐ No

B. Administration and Operation: The following documentation must be submitted with this application. (Please specify location in application of the following supporting documents.)

A copy of the affidavit, corporate charter, articles of incorporation, or other charter documents.

The following section must be completed in its entirety, failure to do so will result in an incomplete application.

Section 4. Attestations:

I, the undersigned, do hereby swear or affirm under oath that the information submitted in this application is true and accurate to the best of my knowledge and belief. If there is any material modification of this information, a notice will be filed with the Department.

Print Name of Officer or Authorized Representative:	Date:
Signature:	Title:

I, the undersigned, do hereby swear or affirm under oath that the entity applying for licensure as a PBM is in compliance with Section 27-45A-1 et. Seq. of the Code of Alabama 1975, as amended and any related regulations or rules adopted by the Commissioner.

Print Name of Officer or Authorized Representative:	Date:
Signature:	Title:

<u>All proprietary information submitted shall be considered confidential under Section 27-45A-4(k) of the Code of Alabama 1975, as amended.</u>

1. association, partnership agreement, trust agreement or other applicable documents, and all amendments thereto

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