



The State of New Hampshire Insurance Department

21 South Fruit Street, Suite 14
Concord, NH 03301

Pharmacy Benefits Manager Application for Registration, RSA 402-N

- Initial Application, \$500
- Renewal Application, \$100 due February 1st each year (All renewal applications must include PBM Annual Rebate Summary spreadsheet. Pages 2-3 may be disregarded unless there have been changes.)

All checks must be made payable to: New Hampshire Insurance Department. Checks must be mailed to the Financial Regulation Division, Insurance Department, 21 South Fruit St., Suite 14, Concord, NH 03301.

All renewal applications and PBM Annual Rebate Summary spreadsheets must be emailed to companylicensing@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.

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

Pharmacy Benefits Manager Name: _____

Trade Name (if any): _____

Domicile: _____ FEIN: _____

Name and address of person licensed should be mailed to: _____

Other New Hampshire Licenses or Certifications of Authority: _____

Compliance Contact

Name: _____ Title: _____

Phone: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

*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.

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: _____

City: _____ State: _____ Zip: _____

Name of health carrier: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Name: _____

Contact Address: _____

City: _____ State: _____ Zip: _____

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

4. 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 before me this _____ (date) by
_____ (Name of person signing this document).

Notary Public Signature: _____

Printed Name: _____

Commission Expires: _____