INSURANCE DEPARTMENT
STATE OF KANSAS
PHARMACY BENEFITS MANAGER
APPLICATION FOR CERTIFICATE OF REGISTRATION

COMMISSIONER OF INSURANCE, Topeka, Kansas:

1. On behalf of: _____
(Name of person, company, corporation, partnership or other legal entity)

with its principal office at: _____
(Street address)

_____
(City, state and zip code)

_____ _____
(Phone) *(Fax)*

_____
(Email address)

I hereby apply for a CERTIFICATE OF REGISTRATION authorizing and empowering the above entity to act as a pharmacy benefits manager within the State of Kansas pursuant to K.S.A. 40-3823.

2. K.S.A. 40-3823(b)(1) requires the following information to be submitted as part of this application:

"The name, address, official position and professional qualifications of each individual who is responsible for the conduct of the affairs of the pharmacy benefits manager, including all members of the board of directors, board of trustees, executive committee, other governing board or committee, the principal officers in the case of a corporation, the partners or members in the case of a partnership or association and any other person who exercises control or influence over the affairs of the pharmacy benefits manager."

The above information must be included with the application at submission or the certificate cannot be provided.

K.S.A. 65-636; 65-1626; 65-1626a; and 65-1643 pertain to the practice of pharmacy and the use of titles like "pharmacy" or any other term designated to take the place of such title. Please check this box to indicate your compliance with the aforementioned Kansas statutes. ☐

3. Administrative address: _____
(Name of administrative contact <u>if different from officers signing below</u>)

_____
(Address of administrative office serving Kansas <u>if different from address above</u>)

_____
(City, state and zip code)

_____ _____
(Phone) *(Fax)*

_____
(Email address)

4. Service of Process Agent: _____

(If neither prior address is in Kansas, name and address in Kansas must be provided)

_____

(Street Address)

_____

(City, state and zip code)

5. Type of entity (check one): ❑ Corporation ❑ Partnership ❑ Individual

Very truly yours,

President: _____

(Signature of corporation president, partner or individual)

_____

(Name typed)

Secretary: _____

(Signature of corporation secretary)

_____

(Name typed)

Date: _____

Mail completed, signed form and $140 application fee to:

Health & Life Division
Kansas Insurance Department
1300 SW Arrowhead Road
Topeka, KS 66604