CONTINUING EDUCATION "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
[] Authorized Insurer
[] Provider of Independent Program of Instruction
[] Other (Describe): _____

General Information:

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

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

Telephone# (____) ____ - ____ - _____ 1-800 (____) ____ - _____ 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 [] Life & Health [] Bail Bond

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

_____ Date: _____
Signature of Authorized Continuing Education Provider Representative

_____
Notary Public

Sworn to and subscribed before me
This _____ day of _____, 20 ____.

My commission expires:_____

MAIL TO:

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

$300 Application fee must be included.