License Application

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PHARMACY BENEFIT MANAGER LICENSE SYSTEM

Before you begin, you will need....

- Registrant's corporate charter, articles of incorporation, and other charter documents
- If applicable, documents pertaining to refusal/denial of registration, license, or certification
- If applicable, documents pertaining to termination of insurer or pharmacy benefit manager

All documents must be in **PDF** format only! Please have documents ready before beginning application to prevent session timeout.

Click **here** for a complete list of information needed.

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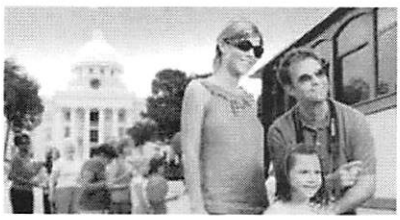

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COMPANIES

Company Search, Filing Requirements, Rate Bull Captives, Clarity Act, etc.

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Have you previously submitted a Pharmacy Benefit Manager application?

- ○ Yes
- ◉ No

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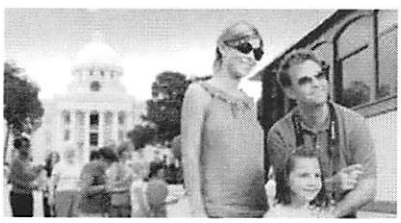

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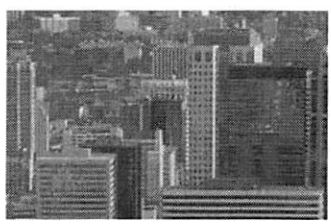

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APPLICATION

Please do not submit applications earlier than November 1st for the following year!

Enter all required information and click Submit.

*** Required**

* Application Type:
- ○ New
- ○ Renewal

* Exact legal name of the Pharmacy Benefit Manager (PBM):

* FEIN/SSN:

* Is the PBM doing business under a name different than the legal name?
- ○ Yes
- ○ No

If yes, provide name:

* Contact Last Name:

* Contact First Name:

Contact MI:

MI

* Title:

* Email Address:

* Business Phone:

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(__) __-____

Alternate Phone:

(__) __-____

* Business Address 1:

Business Address 2:

* City:

* State:

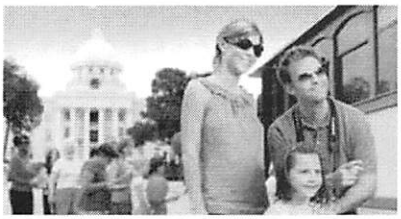
AL

* Zip:

* Country:

Select Country

Submit



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OTHER LICENSE

Transaction Number: [redacted]

* Does the PBM hold any other licenses in Alabama?

- ○ Yes
- ○ No

If yes, list all other license types:

If applicable, PBM Parent Company:

Submit

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PROCESS SERVICE AGENT

Enter all required information and click Submit.

*** Required**

* Transaction Number: [redacted]

* Last Name:

* First Name:

* Title:

* Phone:

* Email:

* Confirm Email:

* Address:

* City:

* State:

* Zip:

Submit

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CONTROL/MANAGEMENT

Enter all required information on each person with management or control over PBM and click Submit. Multiple entries are allowed.

*** Required**

* Transaction Number: [redacted]

* Last Name:

* First Name:

* Title:

* Phone:
(___) ___-____

* Email:

* Confirm Email:

* Address:

* City:

* State:
Select State

* Zip:

Submit

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INTEREST OWNER BENEFICIARY

Enter all required information on each person with a beneficial ownership interest in the PBM and click Submit. Multiple entries are allowed.

*** Required**

Transaction Number: [redacted]

* Last Name:

* First Name:

SSN/FEIN:

* Phone:
(__) __-____

* Email:

* Confirm Email:

* Address:

* City:

* State:
AL

* Zip:

Submit

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COMPLAINT/APPEALS PROCESS CONTACT

Enter all required information and click Submit.

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

*** Required**

* Transaction Number: [redacted]

* Last Name:

* First Name:

* Title:

* Phone:
(__) __-____

* Email:

* Confirm Email:

* Address:

* City:

* State:
Select State

* Zip:

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ORGANIZATION STRUCTURE

Transaction Number: [redacted]

Is this a partnership or other unincorporated association, limited liability company, or corporation? ○ Yes ◉ No

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.

Describe legal structure:

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

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QUALIFICATIONS

Transaction Number: [redacted]

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, enter information below for each incident.

O Yes O No

Type:

Select Type

Date of Denial/Refusal:

Disposition:

Relevant documents pertaining to incidents:

Choose Files No file chosen

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QUALIFICATIONS-RELATIONSHIPS

Transaction Number: [redacted]

Has the applicant had a relationship with an insurer, other than that of a policyholder, terminated for any fraudulent or illegal activities or 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?

○ Yes ○ No

Type:

Select Type

Termination Date:

Describe below:

Relevant documents pertaining to incidents:

Choose Files No file chosen

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DOCUMENTS

Please upload a copy of the registrant's corporate charter, articles of incorporation, or other charter documents.

Browse and load document(s) and click Submit. * Multiple documents allowed

* Transaction Number:

[redacted]

* Load Documents:

Choose Files No file chosen

Submit

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ATTESTATIONS

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

Name of Officer or Authorized Representative:

Title:

Date:

I, the undersigned, do hereby swear or affirm under oath that the entity applying for licensure as a PBM is in a 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.

Name of Officer or Authorized Representative:

Title:

Date:

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

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E-SIGNATURE

By electronically signing below, I do hereby swear and affirm that all information provided is true and correct. I understand that the submission of false information may result in criminal action being taken against me.

Please enter a **four-digit number** of your choosing in the eSignature box to show your intention to sign this document.

eSignature:

Submit

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FEES

Review Application

ALL FEES ARE NONREFUNDABLE!

Transaction Number: [redacted]

Payment Type: (•) E-Check ( ) Credit/Debit Card

Application Fee:	$500.00
Processing Fee:	$4.00
Total Fee:	$504.00

Renewal Fees will vary. How will we handle?

Enter Payment Information

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