

Pharmacy Benefit Manager Consent to Service

Required for pharmacy benefit managers (PBM) that are **not** domiciled in Michigan.

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| Pharmacy Benefit Manager Name | Tax ID Number (FEIN) |
| a pharmacy benefit manager operating under and by the virtue of the laws of the state of (legally created/registered) | |

having been authorized or having applied to act as a pharmacy benefit manager in the State of Michigan, and for the purpose of complying with the provisions of section 11(2)(a)(ii) of the Pharmacy Benefit Manager Licensure and Regulation Act, 2022 PA 11, MCL 550.821, does hereby make, constitute, and appoint the Director of the Department of Insurance and Financial Services of the State of Michigan as its lawful attorney in the State of Michigan, on whom all process of law may be served in any action or proceeding under current or future laws and statutes of Michigan in which said pharmacy benefit manager is a party. Further, said pharmacy benefit manager hereby stipulates and agrees that any legal process affecting such PBM served upon the Director of the Department of Insurance and Financial Services, the Director's successors in office, or designated Deputy, shall have the same effect as if personally served upon the pharmacy benefit manager and shall be deemed sufficient service on said pharmacy benefit manager. This appointment shall remain in force as long as any liability shall remain within the State of Michigan. When process against or affecting said pharmacy benefit manager is served on the Director of the Department of Insurance and Financial Services, the Director's successors in office, or designated Deputy, a copy of such process shall be mailed to:

| | | |
|---------------------|-------|----------|
| Resident Agent Name | | |
| Address Line 1 | | |
| Address Line 2 | | |
| City | State | ZIP Code |

Signed in the city of _____ in the state of _____
 on the _____ day of _____, 20 _____

Certification (to be completed by an officer or director of the pharmacy benefit manager)

I swear under penalty of perjury that the information in this form is true, accurate, and complete.

Name (type or print)

Title (type or print)

Signature (original or electronic only)

This form is authorized by the Michigan Pharmacy Benefit Manager Licensure and Regulation Act ([2022 PA 11; MCL 550.811 et seq.](#)). Failure to complete and submit this form as required could result in denial of your initial or renewal application, a compliance action, or revocation of your authority as an admitted or eligible company in Michigan.

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| When submitted with an application, mail to: DIFS Insurance Licensing PO Box 30165 Lansing, MI 48909-7665 | When not submitted with an application mail to: DIFS Insurance Licensing PO Box 30220 Lansing, MI 48909-7720 |
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Michigan Department of Insurance and Financial Services

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