

Pharmacy Benefit Manager (PBM) Affiliation Statement

Name of Pharmacy Benefit Manager (PBM)	PBM Tax ID number (FEIN)
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Check each box below that describes your relationship to the PBM. Enter all requested information. (Please note: A separate PBM Affiliation Statement must be completed for each individual or entity added. A corporate stockholder should enter primary mailing and business addresses for the corporation.)

<input type="checkbox"/> Officer or Director of the PBM <input type="checkbox"/> Individual holding 10% or more of the stock of the PBM	OR	<input type="checkbox"/> Entity holding 10% or more of the stock of the PBM
Your Name and Title as it relates to the PBM		Name of Corporation
Your Social Security Number		State of Incorporation
		Corporation Tax ID Number (FEIN)
		Percentage of ownership of PBM
		%

MAILING ADDRESS			BUSINESS ADDRESS; check box if same as mailing address <input type="checkbox"/>		
Street Address	Suite No.	Street Address	Suite No.		
City	State	ZIP Code	City	State	ZIP Code
Telephone Number	Email Address	Business Telephone Number	Ext.	Business Email Address	

Please answer all questions completely. If you are completing this form on behalf of an entity, answer on behalf of the entity, not on behalf of you as an individual. If additional space is needed, please clearly identify each response by question number and attach the continuation(s) to this statement. Enter the name and the last four numbers of the Social Security Number or the entity's name and last four numbers of the FEIN in the upper right corner of each attachment. Attachments become part of this verified statement.

<p>1. Have you ever had a PBM certificate of authority, license, or registration suspended, denied, or revoked for cause in another state? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, provide a detailed written statement and all relevant supporting documentation issued by the regulatory authority.)</p>
<p>2. Have you been convicted of a felony, or entered a plea of guilty or nolo contendere to a felony, without regard to whether adjudication was withheld? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, provide a copy of the initial complaint filed, the order resulting from the hearing, a written statement, and any other relevant legal documents for each case.)</p>
<p>3. Have you had a business relationship with an insurance company that was terminated for any alleged fraudulent, illegal, or dishonest activity in connection with the administration of PBM services? <input type="checkbox"/> Yes <input type="checkbox"/> No (Attach specific details separately.)</p>
<p>4. Have you ever been named or involved as a party in an administrative proceeding, including a Financial Industry Regulatory Authority (FINRA) sanction or an arbitration proceeding regarding any professional or occupational license or registration? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, provide a written statement and a copy of the administrative order or other relevant legal documentation for each action.)</p>

CERTIFICATION

I swear under penalties of perjury that the information above and attached is true, accurate, and complete.

Signer's name and title (*typed or printed*)

Signature

Date

Failure to complete or submit this form, misrepresentation, false statement, omission of material fact or fraud in, or in connection with, this statement may result in disciplinary action against any license or Certificate of Authority issued by or pending before the Director of the Department of Insurance and Financial Services.

Please submit this form to:

**Department of Insurance and Financial Services
PO Box 30220
Lansing, MI 48909-7720**



Michigan Department of Insurance and Financial Services

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