

## Pharmacy Benefit Manager Affiliation Statement

Must be completed by individuals responsible for the conduct of the affairs of the pharmacy benefit manager (PBM), including all officers, directors, and individual or corporate (or other entity) owners of 10% or more.

Pharmacy Benefit Manager Name	Tax ID number (FEIN)
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**PBM Relationship:** Check the box that describes your relationship to the PBM and enter all information. Individuals responsible for the conduct of the affairs of the PBM, including each officer, director, and individual or corporate (or other entity) owner of 10% or more must complete an affiliation statement.

<input type="checkbox"/> Officer or Director <input type="checkbox"/> Other Individual Responsible or Owner of 10% or More	
Name	
Title in Relation to PBM	Percentage Ownership of PBM: %
Date of Birth	
Social Security Number	

**OR**

<input type="checkbox"/> Corporate (or other entity) Owner of 10% or More	
Corporation Name	
Incorporation State	Percentage Ownership of PBM: %
Corporation Tax ID Number (FEIN)	
Contact Person	

**Contact Information:** Enter all contact information for the individual responsible including officer, director, or owner. For a corporate (or other entity) owner, include the email address and phone number of the contact person.

Mailing Address Line 1	Mailing Address Line 2	City	State	Zip Code
Business Address Line 1 ( <input type="checkbox"/> same as mailing address)	Business Address Line 2	City	State	Zip Code
Email Address		Phone Number		

**Background Questions:** Answer all questions completely. If you complete this form for a corporate (or other entity) owner, answer on behalf of the corporation not yourself. If additional space is needed, provide the response in an attachment.

1. Have you ever had a PBM certificate of authority, license, or registration suspended, denied, or revoked for cause in another state? <i>If yes, provide a detailed written statement and all relevant supporting documentation issued by the regulatory authority.</i>	<div style="border: 1px solid black; height: 150px; margin-top: 10px;"></div>
<input type="checkbox"/> Yes <input type="checkbox"/> No	

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? *If yes, provide a copy of the initial complaint, the order resulting from the hearing, a written statement, and any other relevant legal final disposition document, any other relevant documents, and a written statement for each case.*

- Yes
- No

3. Have you had a business relationship with an insurance company terminated for alleged fraudulent, illegal, or dishonest activity in connection with the administration of PBM services? *If yes, provide a written statement and supporting documents for each instance.*

- Yes
- No

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? *If yes, provide a written statement and a copy of the administrative order or other relevant legal documentation for each action.*

- Yes
- No

**Certification**

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

Name (type or print)

Title (type or print)

Signature (original or electronic only)

Date

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 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.

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**



**Michigan Department of Insurance and Financial Services**

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