REGISTRATION FOR PHARMACY BENEFIT MANAGERS

INVOICE

Registration is hereby requested as a Pharmacy Benefit Manager in accordance with the Insurance Laws of Florida.

Send the original check made payable to the Florida Department of Financial Services, and mail the check and invoice to the Department of Financial Services, Bureau of Financial Services, P. O. Box 6100, Tallahassee, Florida 32314-1600.

Attach a photocopy of the invoice and check for the amount of the required filing fee for the application being file. If sent electronically, redact the bank account number from the copy of the check for security purposes.

1. Name of Proposed Pharmacy Benefit Manager:

_____

2. Mailing Address:

_____

3. Federal Employer's I.D. No._____

Accounting Information

DRC	RSC	AMOUNT
C	1002F	$5.00

Form OIR-C1-2210
Effective 01/19
Incorporated by Reference in Rule 69O-238.001