Office of Insurance Regulation
Company Admissions

REGISTRATION FORM FOR PHARMACY BENEFIT MANAGERS

This package is designed to assist individuals in preparing the registration form with all the information required by statute and to facilitate expeditious processing of the registration by this Office.

The completed registration package must be submitted to the Office by utilizing the following link, unless otherwise specified herein:

http://www.floir.com/iportal
and select iApply – Online Company Admissions

Any questions concerning this application package or iApply may be directed to lhappcoord@floir.com.

In order for a submission to be considered a complete registration request, all required information must be included in the filing. Filings that do not include all required information will be disapproved or returned.

[Remainder of this page intentionally left blank]

Form OIR-C1-2209
Effective 01/19
Incorporated by Reference in Rules 69O-238.001 and 69O-238.002, F.A.C.

REGISTRATION FORM FOR PHARMACY BENEFIT MANAGERS

Name, address, and telephone number of individual to be contacted regarding this registration form:	
Name:	
Address:	
Telephone:	
E-Mail:	

Note: A copy of the registrant's corporate charter, articles of incorporation, or other charter document will be required in the iApply submission of the registration.

SECTION A – Name and Address of the Registrant

Name of Proposed Pharmacy Benefit Manager:	

Address of the Proposed Pharmacy Benefit Manager:	

[Remainder of this page intentionally left blank]

REGISTRATION FORM FOR PHARMACY BENEFIT MANAGERS

SECTION B – Name, Address, and Official Position of Each Officer and Director

Name:	
Address:	
Official Position:	
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[Attach additional page if necessary]

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
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