



Insurance Administrator (TPA) Renewal Application Additional Questionnaire Form

Please complete the information below in addition to the NIPR Uniform Application and email it to the email address above.

Section 1. Applicant Demographic Information:

Name of Insurance Administrator (TPA):	SCDOI License Number:
Name and Title of Business Contact: (*Must be Officer/Director for the TPA)	Business Contact Direct Telephone and Email: (*Must be for the TPA, not the Compliance Company)
Name and Title of Primary Contact: (*Must be different from the above)	Primary Contact Direct Telephone and Email: (*Must be different from the above)

Applicant's Agent for Service of Process in South Carolina:

Name:	Title:
Direct Telephone:	Contact Email:
Mailing Address:	

Consumer Complaints and Other Compliance Matters Contact Information:

Note: The SCDOI will contact this person regarding consumer complaints and other compliance matters.

Name:	Title:
Direct Telephone:	Contact Email:
Mailing Address:	

Section 2. Business Organization:

<p>Are you authorized to transact business in South Carolina? Attach the Certificate of Authority or Existence from the SC Secretary of State. The Certificate must be for the current year.</p>	<p>Yes – submitted via email to <input type="checkbox"/> specialtylicensing@doi.sc.gov</p>
<p>Indicate the type(s) of services the administrator will provide: Premium Collection Claims Payable Underwriting Advertising Pharmacy Benefits Software Provider Utilization Review Other (please specify): _____</p>	
<p>Attach a list of current officers/directors/owners and provide a Biographical Affidavit for each new officer that has not been submitted. *Note: The NAIC Biographical Affidavit Form is available on our website.</p>	
<p>Attach a copy of annual financial statements or reports for the preceding calendar year, and any other documents that the director or his designee may require to provide financial stability.</p>	

Section 3. Financial Requirements:

Pursuant to §38-51-30, Every administrator shall file and maintain with the Department a surety bond in favor of the State, executed by a surety company authorized to transact business in this State. In lieu of a Bond, a Certificate of Deposit, Letter of Credit, or Corporate Guaranty may be submitted for approval.

<p>Select an option below:</p> <p><input type="checkbox"/> Surety Bond <input type="checkbox"/> Certificate of Deposit <input type="checkbox"/> Letter of Credit <input type="checkbox"/> Corporate Guaranty</p> <p>*Please be advised, at renewal, an increase in security pledged may be requested as stated in SC Code Law §38-51-30.</p>
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Section 4: Business Activity:

<p>1. List all insurance companies that the company has a written agreement with that covers residents of South Carolina. (Attach a separate sheet if needed).</p>	
<p>2. List all self-insured entities that cover residents of South Carolina. (Attach a separate sheet if needed).</p>	
<p>3. List all multiple employer plans that cover residents in South Carolina. (Attach a separate sheet if needed).</p>	
<p>4. List all Pharmacy Benefit Managers and any other entities, not listed in item #'s 1-3, that the company has a written agreement with that covers residents of South Carolina. (Attach a separate sheet if needed).</p>	
<p>5. For each insurer (including any self-insured plans) during the period covered by this report, provide the total premiums collected or managed and the total claims paid or payable by the administrator. (South Carolina business only). Attach a separate sheet if needed. You must provide the calculated total below if any. If the total is zero, put in "0".</p>	

Complete Name of Insurer or Self-Insured Plan	Number of South Carolina Insureds	Amount of South Carolina Premiums	Number of South Carolina Claims Payable

Total Premium Collected:	
Multiply total premium collected by 10%:	

Total Claims Payable:	
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Section 4. Attestation

I certify that I will comply with all applicable provisions of Title 38, Chapter 51 of the South Carolina Code of Laws. I certify all information submitted on this form and attachments is true and accurate. I understand that providing false information on this form may result in the revocation of the license or imposition of administrative penalties for the Applicant under which this form is required.

Print Name of Officer or Authorized Representative:	Title:
Signature:	Date:

Subscribed and sworn to me before this _____ day of _____, 20_____
 Notary Signature _____
 My Commission Expires _____
 County of _____
 State of _____

(Notary Seal Affixed Here)

Please be aware that all correspondence regarding this application will occur via email through our online system. The email address used for this correspondence is sbs@naic.org. We recommend you save this email address to ensure you receive any future system-generated emails. However, **please do not reply to sbs@naic.org, as messages sent to that address will not be received.** All correspondence and documents regarding your license should be sent to specialtylicensing@doi.sc.gov.