

ALASKA DIVISION OF INSURANCE
333 WILLOUGHBY AVENUE, 9TH FLOOR
P.O. BOX 110805
JUNEAU, AK 99811-0805

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THIRD PARTY ADMINISTRATOR ERISA ANNUAL EXEMPTION FILING FORM

Alaska Statute (AS) 21.27.630 has provisions which exempt a person from registering as a Third-Party Administrator (TPA) if the TPA only provides services to bona fide employee benefit plans that are established by an employer or an employee organization, or both, for which the insurance laws of this state are preempted under the Employee Retirement Income Security Act of 1974.

In order to maintain continuance of this exemption under AS 21.27.630(i), you must submit the enclosed form indicating you are claiming exemption from registration as a TPA based on the Employee Retirement Income Security Act of 1974 (ERISA). **THIS MUST BE RECEIVED BY THE DIRECTOR ON OR BEFORE FEBRUARY 1.**

Failure to submit the certification as required within the specified deadline will nullify the firm's exempt status and may require the firm to file and obtain registration as a TPA if they continue to transact business in our state.

1	NAME _____																																											
2	LIST ANY OTHER ASSUMED, FICTITIOUS, ALIAS OR TRADE NAMES UNDER WHICH YOU ARE DOING BUSINESS OR INTEND TO DO BUSINESS. _____																																											
3	TYPE OF BUSINESS Check the legal business type, license class(es) and line(s) of authority for which you are applying. Check the last column if you have been previously licensed in Alaska: <table style="width: 100%; border: none;"> <tr> <td style="border: none;">Legal Business Type</td> <td style="border: none;">C – Corporation</td> <td style="border: none;">P – Partnership</td> <td style="border: none;">S – Sole Proprietorship</td> <td colspan="2" style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">LLC – Limited Liability Corporation</td> <td style="border: none;"></td> <td style="border: none;">LLP – Limited Liability Partnership</td> <td colspan="2" style="border: none;"></td> </tr> </table> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <thead> <tr> <th colspan="5" style="text-align: left;">Legal Business Type</th> <th style="text-align: left;">Incorporation/Formation Date</th> <th style="text-align: left;">FEIN</th> <th style="text-align: left;">State of Domicile</th> <th style="text-align: left;">Country of Domicile</th> </tr> <tr> <th style="width: 15%;">C</th> <th style="width: 15%;">P</th> <th style="width: 15%;">S</th> <th style="width: 15%;">LLC</th> <th style="width: 10%;">LLP</th> <th style="width: 20%;">(month)____(day)____(year)_____</th> <th style="width: 15%;"></th> <th style="width: 10%;"></th> <th style="width: 10%;"></th> </tr> </thead> <tbody> <tr> <td style="height: 20px;"></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>					Legal Business Type	C – Corporation	P – Partnership	S – Sole Proprietorship				LLC – Limited Liability Corporation		LLP – Limited Liability Partnership			Legal Business Type					Incorporation/Formation Date	FEIN	State of Domicile	Country of Domicile	C	P	S	LLC	LLP	(month)____(day)____(year)_____												
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4	ADDRESSES																																											
Business Physical Address			City		State		Zip or Foreign Country																																					
Mailing Address			P.O. Box		City		State																																					
							Zip or Foreign Country																																					
5	BUSINESS NUMBERS																																											
Phone # _____			Fax # _____		E-mail Address _____																																							
6	DESIGNATED RESPONSIBLE PERSON (COMPLIANCE OFFICER)																																											
Last Name			First Name		Middle		SSN																																					
7	FOR SELF-INSURED PLANS ONLY																																											
I certify that _____ performs premium accounting and premium billing within our state for only bona fide employee benefit plans that are established by an employer or an employee organization, or both, for which the insurance laws of this state are preempted under ERISA.																																												
Plan Names					Location																																							
8	KEY EMPLOYEES																																											
Identify the key personnel who supervise or have responsibility over personnel performing TPA administrative functions. A listing may be attached.																																												

BACKGROUND INFORMATION

Please read the following very carefully and answer every question:

1. Since your firm was granted exemption from the TPA registration, has the business, or any owner, partner, officer, or director ever been convicted of, or are you currently charged with committing a crime, whether or not adjudication was withheld? Yes No

"Crime" includes a misdemeanor, felony, or a military offense. You may exclude misdemeanor traffic citations and juvenile offenses.

"Convicted" includes, but is not limited to, having been found guilty by verdict of a judge or jury, having entered a plea of guilty or nolo contendere, or having been given probation, a suspended sentence or a fine.

If you answer yes, you must attach to this application:

- a) a written statement explaining the circumstances of each incident,
- b) a certified copy of the charging document, and
- c) a certified copy of the official document which demonstrates the resolution of the charges or any final judgment.

2. Since your firm last filed with our office, has the firm or any owner, partner, officer, or director ever been involved in an administrative proceeding regarding any professional or occupational license? Yes No

"Involved" means having a license censured, suspended, revoked, canceled, terminated; or, being assessed a fine, placed on probation or surrendering a license to resolve an administrative action.

"Involved" also means being named as a party to an administrative or arbitration proceeding which is related to a professional or occupational license. "Involved" also means having a license application denied or the act of withdrawing an application to avoid a denial. You may exclude terminations due solely to noncompliance with continuing education requirements or failure to pay a renewal fee.

If you answer yes, you must attach to this application:

- a) a written statement identifying the type of license and explaining the circumstances of each incident,
- b) a copy of the Notice of Hearing or other document that states the charges and allegations, and
- c) a copy of the official document which demonstrates the resolution of the charges or any final judgment.

3. Has any demand been made or judgment rendered against you or the firm or any owner, partner, officer, or director for overdue monies by an insurer, insured or producer, or have you ever been subject to a bankruptcy proceeding? Yes No

If you answer yes, submit a statement summarizing the details of the indebtedness and arrangements for repayment.

4. Has the firm or any owner, partner, officer, or director ever been found liable in, any lawsuit or arbitration proceeding involving allegations of fraud, misappropriation or conversion of funds, misrepresentation, or breach of fiduciary duty? Yes No

If you answer yes, you must attach to this application:

- a) a written statement summarizing the details of each incident,
- b) a copy of the Petition, Complaint, or other document that commenced the lawsuit or arbitration, and
- c) a copy of the official document which demonstrates the resolution of the charges or any final judgment.

5. Has the firm or any owner, partner, officer, or director ever had an insurance agency contract or any other business relationship with an insurance company terminated for any alleged misconduct? Yes No

If you answer yes, you must attach to this application:

- a) a written statement summarizing the details of each incident and explaining why you feel this incident should not prevent you from receiving an insurance license, and
- b) certified copies of all relevant documents.

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I hereby certify under penalty of perjury, that:

1. All of the information submitted in this application and attachments is true and complete and I am aware that submitting false information or omitting pertinent or material information in connection with this application is grounds for license or registration revocation and may subject me to civil or criminal penalties.
2. Where required by law, I hereby designate the Director of Insurance to be its agent for service of process regarding all insurance matters and agree that service upon the Alaska Director of Insurance is of the same legal force and validity as personal service upon me.
3. I grant permission to the Director of Insurance for which this application is made to verify any information supplied with any federal, state or local government agency, current or former employer or insurance company.
4. I authorize the State of Alaska to give any information it may have concerning me to any federal, state or municipal agency, or any other organization and I release the State of Alaska and any person acting on their behalf from any and all liability of whatever nature by reason of furnishing such information.
5. I acknowledge that I am familiar with the Alaska insurance laws and regulations.

Must be signed by an owner, officer, partner, director, or member of the business entity.

Signature

Type or Printed Name