



**ARKANSAS INSURANCE DEPARTMENT
LICENSE DIVISION
1 COMMERCE WAY
LITTLE ROCK, AR 72201
PHONE: 501-371-2750**

**SELF-FUNDED SINGLE EMPLOYER PLANS,
COLLECTIVELY BARGAINED WELFARE BENEFIT PLANS,
MULTIPLE EMPLOYER TRUSTS AND MULTIPLE
EMPLOYER WELFARE ARRANGEMENTS
(Ark. Code Ann. § 23-92-101)**

1. Name of Plan: _____
2. Tax ID Number of Plan: _____
3. Address of Plan: _____
4. Contact Name and Title _____ Tel. No. _____
5. Type of Plan, Arrangement, Association or Trust:
 - Self Funded Single Employer Plan
 - Collectively Bargained Welfare Benefit Plan (Taft-Hartley Trust)
 - Multiple Employer Trust
 - Fully Insured Multiple Employer Welfare Arrangement
 - Not Fully Insured Multiple Employer Welfare Arrangement
6. List all States in which the Plan is registered or licensed (attach copies of license/registration to this form):

7. List all States in which the Plan is doing business or covers individuals:

8. Has the Plan had any complaints regarding claim payment in other states: Yes No
(If yes, attach a copy of the documentation of the complaint and documentation of the resolution of the complaint)
9. Third Party Administrator: Name _____
Federal Tax ID _____ Address _____
Contact Name and Title _____
Tel. No. _____
10. Number of Individual Arkansas Residents Covered by the Plan or Arrangement _____

11. If a fully insured multiple employer welfare arrangement or trust, state name, address and telephone number and the NAIC number of the disability or health insurer underwriting the plan: *(A copy of the declaration page/ certificate and policy must be attached to this application.)*

Name of Company _____ NAIC # _____

Contact Name and Title _____ Tel. No. _____

12. If a multiple employer welfare arrangement or trust which is not fully insured, state name, address and telephone number of person(s) administering the plan, whether or not a third party administrator.

Name of Administrator _____

Address of Administrator _____

Contact Name and Title _____ Tel. No. _____

AFFIDAVIT

I, the undersigned, do hereby swear or affirm under oath that the information submitted above is true and accurate to the best of my knowledge and belief.

Name and Title _____ Date _____

State of _____

County of _____

Subscribed to and sworn or affirmed before me on this _____ Day of _____, 20____.

My Commission Expires: _____

Seal

Notary Public