



ARKANSAS
Insurance Department

ARKANSAS INSURANCE DEPARTMENT

ATTN: PBM Legal Division

1 Commerce Way
Little Rock, AR 72202
501-371-2820
FAX: 501-371-2639

Arkansas (AR) Pharmacy Benefit Manager (PBM) Name Change Application

Current name of business entity: _____

New name of business entity: _____

Previous mailing address, if applicable:

Street or P.O. Box: _____ City: _____ State: _____ Zip: _____

New mailing address, if applicable:

Street or P.O. Box: _____ City: _____ State: _____ Zip: _____

Previous phone number, if applicable: _____

New phone number, if applicable: _____

Please provide the following information for the new business entity:

- 1) Evidence the PBM's surety bond issued is in force for new business entity.
- 2) New fiscal structure of business plan, audited by third party with supporting documentation, including a breakout schedule showing the financial position of the PBM and its subsidiaries, and a list identifying any parent company or companies, and any subsidiaries.
- 3) A report of each bank identification number (BIN), group number, and processor control number (PCN) used by the PBM. Distinguish all unique combinations thereof, along with the number of lives covered and plan type as described in Attachment 1.

- 4) Contact information for the below, including names, titles mailing addresses, email addresses, and phone numbers:
- a) MAC/NADAC Complaints Contact;
 - b) PBM Licensing Contact;
 - c) Government Relations / Legal Contact;
 - d) Board Members;
 - e) Board of Trustees;
 - f) Executive Committee;
 - g) Principal officers, in the case of a corporation;
 - h) Policies or procedures;
 - i) Partners or members, in the case of a partnership or association.
- 5) List of affiliates and/or affiliate structure for the new business entity.
- 6) If the PBM contracts out the handling of PBM functions, please identify the company (or companies) and the function(s) it performed on behalf of the company.
- 7) Current number of enrollees or beneficiaries to be administered by the PBM in AR: _____
Project number of enrollees or beneficiaries to be administered by the PBM in AR in the coming year: _____

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.

Officer Name:

Please Print: _____

Please Sign: _____

Date Signed: _____

NOTARY SECTION

Subscribed and sworn to before me, by the said _____.

This ____ day of _____, 20__, to certify which witness by hand and seal of office.

Notary Public Signature: _____

Printed Name: _____

My Commission expires _____, 20_____.