Department of Consumer and Business Services
Division of Financial Regulation
P.O. Box 14480, Salem, Oregon 97309-0405
350 Winter St. NE, Salem, Oregon 97301-3883
Phone: 503-947-7982 Fax: 503-947-7862
E-mail: orinsreg.ins@state.or.us
dfr.oregon.gov

☐ **New application.**

☐ **Renewal application.**

Pharmacy Benefit Manager Licensing Application

Applicant:

Applicant name

Business address | FEIN

City | State | ZIP

Applicant's principal officers

Officer name | Job title

Business address

City | State | ZIP

Officer name | Job title

Business address

City | State | ZIP

Officer name | Job title

Business address

City | State | ZIP

Officer name | Job title

Business address

City | State | ZIP

Applicant's officer/employee to be contacted regarding regulatory compliance concerns:

Name | Job title

Business address

City | State | ZIP

Phone Number | Email

Provide business telephone number and business e-mail address where Applicant's personnel directly responsible for the processing of maximum allowable cost appeals may be contacted, if different from above.

Phone number | Email

Applicant shall respond "Yes" or "No" to each of the following questions, and shall explain any "Yes" response in the Supplemental Information space provided below. Has Applicant or any person with control of the Applicant:

1. Ever falsified an application for registration or for the renewal of a registration or engaged in any dishonest act in relation to the application? ☐ Yes ☐ No
2. Ever engaged in dishonesty, fraud or gross negligence in the conduct of business as a pharmacy benefit manager? ☐ Yes ☐ No
3. Ever engaged in conduct that resulted in a conviction of a felony under the laws of any state or of the United States, to the extent that such conduct may be considered under ORS 670.280? ☐ Yes ☐ No
4. Ever been convicted under the laws of any state or of the United States of any crime of which an essential element is dishonesty or fraud? ☐ Yes ☐ No
5. Ever had a certificate of authority or authority to conduct business as a pharmacy benefit manager denied, revoked or suspended in another state? ☐ Yes ☐ No
6. Ever failed to pay a civil penalty imposed by final order of the department or to comply with the terms of suspension set by the department? ☐ Yes ☐ No
7. Ever failed to meet the terms of a consent decree approved by a court of competent jurisdiction in this state, or a consent order made between the department and the pharmacy benefit manager? ☐ Yes ☐ No
8. Ever refused to be examined or to produce accounts, records or files for examination, including the refusal by any officer of the applicant or registrant to give information with respect to the affairs of the pharmacy benefit manager, or refused to perform any other legal obligation with respect to an examination by the department? ☐ Yes ☐ No
9. Ever violated any rule or order of the department or any provision of the Insurance Code? ☐ Yes ☐ No

Supplemental Information (with cross reference as appropriate). Attach additional pages, if needed:

List all other jurisdictions in which the Applicant is or has been registered, licensed or certified to transact business as a pharmacy benefit manager within the past ten (10) years.

Certification of applicant: Applicant certifies that the information contained in this Application is true and correct according to the best of Applicant's knowledge, information and belief. Applicant understands that Applicant is required to provide written notification to the department of any change in such information.

Application submitted by (person authorized to submit this application):

Name | Job title

Signature | Date

DCBS Consumer and Business Services

440-4971 (1/18/COM)

Application fee:
The application fee is $**1,100**

Make check or money order payable to: Department of Consumer and Business Services.

Mail licensing application with payment to:
DCBS — Fiscal Services
P.O. Box 14610
Salem, OR 97309-0445

Secure fax for credit card payments:
503-947-2333

If paying by credit card, applicant must sign credit-card information box.

☐ Visa ☐ MasterCard ☐ Discover Phone:

Cardholder signature | Expiration date

Name of cardholder as shown on credit card

Credit card number | $ Amount

Fiscal use only: 92010/1582
Fee: $1,100