STATE OF CONNECTICUT
INSURANCE DEPARTMENT

PHARMACY BENEFITS MANAGER (PBM) SUPPLEMENTAL FORM

Section 38a-479bbb, Connecticut General Statutes requires all Pharmacy Benefits Managers (PBMs) operating in the State of Connecticut to obtain a certificate of registration. Any new PBM seeking to do business in Connecticut must first obtain a Certificate of Registration.

The State of Connecticut Insurance Department (the Department) is charged with registering PBM entities. If you have any questions about your responsibility to register, please refer to C.G.S. §38a-479bbb for more information.

Instructions:

- Please complete this entire form, including the checklist, Bond worksheet, and CEO certification. Both this supplemental form and the NIPR online application must be newly completed each year.
    - If you have not submitted the NIPR online application, you must submit through NIPR before completing this supplemental form.
        - If you are submitting a new registration:
            - Go to www.nipr.com. Under Licensing Center, select "Apply for a New License."
        - If you are submitting a renewal registration:
            - Go to www.nipr.com. Under Licensing Center, select "Renew an Existing License."
        - You will submit payment through NIPR.

- If you have any questions, please e-mail us at: cid.tpa@ct.gov, Attn: PBM.

Name of PBM: _____

PBM Tax Identification Number (TIN/FEIN): _____

PBM NPN#: _____

NIPR Transaction #: _____

***Contact Information at PBM*:**

Name: _____

Title: _____

Mailing Address:

Phone Number: _____

Fax Number: _____

E-Mail(s): _____

Name & Description of Controlling Company or Organization:

Controlling Company Contact Name: _____

Controlling Company Business Address: (must be physical address / P.O. Box not allowed)

Controlling Company Mailing Address (if different / P.O. Box allowed):

Controlling Company Email(s): _____

Controlling Company Phone(s): _____

NIPR Transaction #: _____

How many total enrollees are served by the PBM:

Nationwide: _____

Connecticut: _____

List all entities on whose behalf the PBM has contracts or agreements to provide pharmacy benefit services to Connecticut enrollees (e.g. Managed Care Organizations):

What is the name and address of the PBM's agent for service of process in Connecticut?

List the PBM's principal owners.

NIPR Transaction #: _____

ADDITIONAL REQUIREMENTS:

- A certificate from the Secretary of State regarding the PBMs good standing to do business in the state. **This must be <1 year old**.

☐ *Document in Warehouse* *Date Added:* _____

☐ *Document to Follow*

- The name, address, official position, and professional qualifications of each person responsible for running the PBM. Such people include:
  - (1) the principal officers, partners, or association members.
  - (2) all members of the boards of directors, trustees, and executive and governing committees; and
  - (3) any other person exercising control or influence over the PBM.

☐ *Document in Warehouse* *Date Added:* _____

☐ *Document to Follow*

- The name, address, official position and professional qualifications of each individual who is a member of the controlling company's board of directors or other policy-making body and of those executive officers who are responsible for the controlling company's activities with respect to pharmacy benefits services;

☐ *Document in Warehouse* *Date Added:* _____

☐ *Document to Follow*

- In the case of an out-of-state PBM, a certificate that such PBM is in good standing in its state of organization. **This must be <1 year old.**

☐ *Document in Warehouse* *Date Added:* _____

☐ *Document to Follow*

- A contingency plan describing how contracted pharmacy benefits services will be provided in the event of insolvency of the PBM.

☐ *Document in Warehouse* *Date Added:* _____

☐ *Document to Follow*

NIPR Transaction #: _____

- Financial information concerning the PBM, including:
  - the most recently concluded fiscal year-end financial statements for the PBM and its controlling company, which statements have been reviewed or audited by an independent certified public accountant (CPA) under GAAP;
  - the names and addresses of the public accounting firm and internal accountant(s) preparing or assisting in the preparation of such financial statements; and
  - evidence of a surety bond in an amount equivalent to ten per cent of one month of claims in this state over a twelve-month average, except that such bond shall not be less than twenty-five thousand dollars or more than one million dollars.
  - **If the bond is more than one year old, please provide a continuation certificate.**

☐ *Document in Warehouse* *Date Added:* _____

☐ *Document to Follow*

NIPR Transaction #: _____

Financial Security Requirement:

Per Connecticut General Statute §38a-479bbb, subsection (c) the financial security amount shall be "evidence of a surety bond in an amount equivalent to ten (10%) of one month of claims in this state over a twelve-month average, except such bond shall not be less than twenty-five thousand or more than one million dollars."

Enter below the amount of the average monthly Connecticut claims over the last twelve months.

If ten percent (10%) of the monthly average is less than twenty-five thousand dollars ($25,000), the surety bond shall be in the amount of twenty-five thousand dollars ($25,000).

NOTE: If ten percent (10%) of the monthly average is greater than one million dollars ($1,000,000), the surety bond shall be in the amount of one million dollars ($1,000,000).

Calculation of Surety Bond: must be between $25,000 and $1,000,000.

Calculation of Surety Bond

Period beginning:	**Month**	**Day**	**Year**
Period ending:	**Month**	**Day**	**Year**

Total Connecticut claims over the prior twelve months:

$_____

Average Monthly Claims:
(Connecticut business only – one 12th of the total claims in the prior twelve months)

$** 0.00 _____ Multiply by 10% = Surety Bond amount **$ 0.00 _____

NIPR Transaction #: _____

CEO CERTIFICATION OF ACCURACY

I, _____, _____ of
(Printed Name) (Title)

_____, hereby certify that
(Pharmacy Benefits Manager)

I have reviewed the information submitted in accordance with C.G.S. 38a-479bbb, and that the information is true and accurate. I understand that any material modification of any matter or document furnished pursuant to this supplemental form must be filed with the Insurance Commissioner within thirty (30) days of such modification, including supporting documents to explain the modification.

_____ _____
(Signature of CEO) (Date)

SAMPLE-BOND FORM

STATE OF CONNECTICUT
Pharmacy Benefits Manager (PBM) BOND

KNOW ALL MEN BY THESE PRESENTS

That we, _____ of the
(Name of PBM)

County of _____ State of _____

as Principal, and _____, a surety

company having its principal place of business in _____

County of _____State of _____duly authorized

to do business in the State of Connecticut, as Surety, are held and firmly bound unto the

member/providers of the Pharmacy Benefits Manager named, as Obligees, in the sum of

_____ dollars ($_____) for the payment of which sum the said Principal and Surety do jointly and severally bind themselves, their heirs, executors, administrators, successors, and assigns, and each and every one of them firmly by these presents.

THE CONDITION OF THIS OBLIGATION IS SUCH THAT, the Principal has made application to the Insurance Commissioner of the State of Connecticut for registration to engage in the business of a Pharmacy Benefits Manager (PBM) in accordance with the provisions of Connecticut General Statute §38a-479bbb and any regulation promulgated thereunder. This surety is intended for the sole purpose of meeting the obligation as described in C.G.S. §38a-479bbb subsection (c) for the exclusive use of paying any outstanding amounts owed in the event of insolvency or nonpayment.

PROVIDED HOWEVER, that all obligations upon this bond shall cease upon the voluntary or involuntary termination of such registration except as to such liability as shall have been accrued thereto.

IN WITNESS WHEREOF, the said Principal and Surety have signed and sealed this instrument this _____ day of _____ 20_____.

WITNESS

_____ By _____ L.S.

(As to Principal) _____ L.S.

_____ By _____ L.S. Corporate Seal

(As to Surety) _____ L.S.

_____ L.S.