



Pharmacy Benefits Manager (PBM) Certificate of Registration (*Initial*) *Instructions and Application*

Public Act 07-200, (codified as Section 38a-479aaa, Connecticut General Statutes) requires all Pharmacy Benefits Managers (PBMs) operating in the State of Connecticut on January 1, 2008, to obtain a certificate of registration not later than April 1, 2008. 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 [CT Public Act 07-200](#) for more information.

Instructions:

- To assure that a PBM certificate of registration is issued timely, the Department recommends that applications be submitted with the \$100 nonrefundable application fee.
- Connecticut law requires that applications for registration be submitted prior to doing business in the State of Connecticut.
- The application must be completed, including all attachments and signed by the CEO of the PBM entity certifying that all information provided is true and accurate.
- Submit your application, attachments and fee to:

State of Connecticut
Insurance Department
Pharmacy Benefits Manager Registration
P O Box 816
Hartford, CT 06142-0816

Hand delivery or Overnight delivery address ONLY:

State of Connecticut
Insurance Department
Pharmacy Benefits Manager Registration
153 Market Street, 7th floor
Hartford, CT 06103



**Pharmacy Benefits Manager (PBM)
Certificate of Registration (Initial)
*Instruction and Application***

Name of PBM: _____

PBM Tax Identification Number (TIN/FEIN) _____

PBM Business Address: _____

PBM Mailing Address (if different): _____

PBM Phone Number: _____

Contact Information (used by the Department for all future correspondence):

Name: _____ **Title:** _____

Mailing Address: _____

Phone number: _____ **FAX number:** _____

E-mail address: _____

Name and description of controlling company or organization: _____

Controlling company's or organization's contact name: _____

Business Address: _____

Mailing Address (if different): _____

Has any suspension, sanction or disciplinary action been taken against the PBM in Connecticut or any other state?

- No
- Yes **If answered yes, explain:**

Has any suspension, sanction or disciplinary action been taken against the controlling company or organization in Connecticut or any other state?

- No
- Yes **If answered yes, explain:**

Describe the PBM's service area: _____

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):

PLEASE SUBMIT THE FOLLOWING AS ATTACHMENTS:

- [] **A Certificate from the Secretary of State affirming that the PBM and its controlling company or organization (if applicable) is in good standing in Connecticut. In addition, for out of state PBMs, controlling companies or organizations, a certificate that such PBM, controlling company or organization is in good standing in its state of organization.**
- [] **A list of the names, addresses, official positions, and professional qualifications of the persons responsible for conducting the affairs of 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.**
- [] **A list of the names, addresses, official positions, and professional qualifications of the persons responsible for operation of the PBM's controlling company or organization. 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.**
- [] **A list of the PBM's principal owners.**
- [] **A list of the controlling company's or organization's principal owners.**
- [] **The name and address of the PBM's agent for service of process in Connecticut.**
- [] **A contingency plan describing how contracted pharmacy benefit services will be provided in the event of insolvency.**
- [] **Copies of PBM certificates of registration or PBM licenses held in other states**
- [] **Proof that the PBM meets the surety bond requirements as described in P.A. 07-200. The surety bond must be held exclusively for use in paying any outstanding amounts owed participating members/providers in the event of insolvency or nonpayment. [Sample bond language is attached.] Please note that the beneficiaries of the surety bond are the members/providers.**

Note: *Under no circumstance should the State of Connecticut or the State of Connecticut Insurance Department be named as the beneficiary.*

- [] **The most recently concluded fiscal year-end financial statements for the PBM AND**
- [] **The most recently concluded fiscal year-end financial statements for the controlling company or organization.**
 - **Financial statements must include an audit opinion rendered by an independent certified public accountant (CPA) on the statements stating that they were prepared in accord with generally accepted accounting principles (GAAP).**

[] Provide the names and addresses of the public accounting firm and internal accountant(s) preparing or assisting in the preparation of such financial statements.

Financial Security Requirement:

Per Connecticut Public Act 07-200 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). 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:

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)

\$ _____ Multiplied by 10% = Surety Bond Amount \$ _____

CEO CERTIFICATION OF ACCURACY

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

_____, hereby certify that
(Pharmacy Benefits Manager)

I have reviewed the information submitted in accordance with Connecticut Public Act 07-200, and that the information is true and accurate. I understand that any material modification of any matter or document furnished pursuant to this application 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 WHEREAS, 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 Public Act 07-200 and any regulation promulgated thereunder. This surety is
intended for the sole purpose of meeting the obligation as described in Public Act 07-200 Sec 2.(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

(As to Principal) By _____ L.S.

(As to Surety) By _____ L.S. Corporate Seal

_____ L.S.
_____ L.S.