State of Connecticut
REGISTRATION OF PHARMACY BENEFITS MANAGERS

Application for EXEMPTION **filed in accordance with Public Act 07-200**

1.Name & Address of Pharmacy Benefit Manager:
_____

Address: _____
_____
_____

2.Contact Person at Pharmacy Benefit Manager:
Name:_____
Phone Number: (_____)_____
E-Mail Address: _____

3.Name & Address of Health Insurer, Health Care Center, Hospital Service Corporation, Medical Service Corporation or Fraternal Benefit Society:
_____
_____
_____

4.Contact Person at Entity listed in 3 above:
Name:_____
Phone Number: (_____)_____
E-Mail Address: _____

CEO CERTIFICATION OF ACCURACY

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

_____, hereby certify that
(Name of Health Insurer HealthCare Center, Hospital or Medical Service Corporation, or Fraternal Benefit Society)

_____(name of Pharmacy Benefit Manager) is operating as a division or line of business under, or as a subsidiary or affiliated company to, _____(name of entity) and therefore is not subject to the registration requirements of Public Act 07-200.

_____ _____
(Signature of CEO) **(Date)**