Hawai`i Insurance Division
Department of Commerce and Consumer Affairs
335 Merchant Street – Room 213
Honolulu, Hawai`i 96813

PHARMACY BENEFIT MANAGER ("PBM") APPLICATION / RENEWAL

Note: If this is a renewal and there are no changes to the previous filing, please fill in Box No.'s 1 – 3, and 9 – 12.

1. This is ☐ an Application. ☐ a Renewal.

2. Name of PBM		a) FEIN of PBM or, if an individual, last 4 digits of the SS#
Business Address (P. O. Box is not an acceptable Business Address)		
b) Street		c) Suite
d) City	e) State	f) Zip Code or Country
g) Phone Number ( ) Ext.	h) Fax Number ( )	i) Business E-mail
Mailing Address		
j) Street or P.O. Box		k) Suite
l) City	m) State	n) Zip Code or Country

3. Name of person applying for or renewing the registration of the PBM		a) Title or Position
b) Professional Qualification(s)		
Business Address		
c) Street		d) Suite
e) City	f) State	g) Zip Code or Country
h) Phone Number ( ) Ext.	i) Fax Number ( )	j) Business E-mail Address

4. Hawai`i Agent for Service of Process		
Business Address for Hawaii Agent for Service of Process (P. O. Box is not an acceptable Business Address)		
a) Street		b) Suite
c) City	d) State	e) Zip Code or Country
f) Phone Number ( ) Ext.	g) Fax Number ( )	h) Business E-mail Address

DO NOT WRITE IN THIS BOX – For State Use Only

VID# _____ PBM _____ I-30 $ _____

I-15 $ _____

I-18 $ _____

The PBM application shall include the name, address, official position, and professional qualifications of each individual who is responsible for the conduct of the affairs of the pharmacy benefit manager, including all members of the board of directors; board of trustees; executive commission; other governing board or committee; principal officers, as applicable; partners or members, as applicable; and any other person who exercises control or influence over the affairs of the pharmacy benefit manager. Please use additional pages as necessary and attach them to this application.

5. Name		a) Title or Position
b) Professional Qualification(s)		
c) Street or P. O. Box		d) Suite
e) City	f) State	g) Zip Code or Country

6. Name		a) Title or Position
b) Professional Qualification(s)		
c) Street or P. O. Box		d) Suite
e) City	f) State	g) Zip Code or Country

7. Name		a) Title or Position
b) Professional Qualification(s)		
c) Street or P. O. Box		d) Suite
e) City	f) State	g) Zip Code or Country

8. Name		a) Title or Position
b) Professional Qualification(s)		
c) Street or P. O. Box		d) Suite
e) City	f) State	g) Zip Code or Country

9. Original signature of person applying for or renewing the registration of the PBM	10. Date
11. Print Name of Signer	12. Title or Position

Make check payable to DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS. Submit applicable fees with your completed registration form to:

Attn: Licensing Branch
Insurance Division
Department of Commerce & Consumer Affairs
335 Merchant Street, Room 213
Honolulu, HI 96813

If you have any questions regarding this form, please e-mail inslic@dcca.hawaii.gov or call 808-586-2788.