

**MARYLAND INSURANCE ADMINISTRATION  
LIMITED LINES LICENSES AND REGISTRATIONS SUPPLEMENT**

**1. APPLICATION INFORMATION**

Applicant Name: \_\_\_\_\_

SSN/FEIN: \_\_\_\_\_ NIPR Transaction #: \_\_\_\_\_

License / Registration Type: (Please Select One)	<input type="checkbox"/>	Portable Electronics Insurance Limited Lines	<input type="checkbox"/>	Viatical Life Settlements Broker Registration
	<input type="checkbox"/>	Motor Vehicle Rental Company Limited Lines	<input type="checkbox"/>	Third Party Administrator
			<input type="checkbox"/>	Viatical Life Settlements Provider Registration

**2. MUST BE COMPLETED BY ALL APPLICANTS**

List all owners, partners, officers, directors, members, managers, and/or stockholders owning 10% or more interest in the firm. (Attach additional sheets if necessary)

Full Name:		Title:		SSN:		% of ownership _____
Address:						
Full Name:		Title:		SSN:		% of ownership _____
Address:						

**3. PORTABLE ELECTRONIC INSURANCE APPLICANTS ONLY**

Please list the requested information below. The kind of insurance must be filed by an authorized insurer and accepted by the Insurance Commissioner.

INSURANCE TYPE	AUTHORIZED INSURANCE COMPANY UNDERWRITING THE COVERAGE	SERFF FILING NUMBER
PORTABLE ELECTRONICS INSURANCE		

Identify at least one officer or employee of the vendor who is designated as the person responsible for the vendor's regulatory compliance.

Full Name:		Title:		SSN:		If owner % of ownership _____
Address:						% _____

Was more than 25% of the vendors' revenue in the preceding year derived from the sale of Portable Electronics Insurance?  Yes  No  
(If yes please provide the information requested below for all officers, directors, and shareholders of record under the Federal Securities Law.)

Full Name:		Title:		SSN:		% of ownership _____
Address:						
Full Name:		Title:		SSN:		% of ownership _____
Address:						
Full Name:		Title:		SSN:		% of ownership _____
Address:						

"I solemnly affirm under the penalties of perjury and upon personal knowledge that the statements of the foregoing paper are true."

\_\_\_\_\_  
Print Full Name of Vendor Designated Responsible Individual

\_\_\_\_\_  
Signature Vendor Designated Responsible Individual

**4. MOTOR VEHICLE RENTAL COMPANY APPLICANTS ONLY**

Check below the kinds of insurance for which you are applying to sell. These kinds of insurance must be filed by an authorized insurer and accepted by the Insurance Commissioner. Rental Company Type:  **Company**     **Franchisee**

INSURANCE TYPE:	AUTHORIZED INSURANCE COMPANY UNDERWRITING THE COVERAGE:	FORM NUMBER:
<b>EXCESS LIABILITY</b> (includes BI, PD, & UM)		
<b>ACCIDENT &amp; HEALTH</b> ( includes accidental death, medical expenses for injuries, and ambulance)		
<b>PERSONAL EFFECTS</b> (includes coverage for theft or damage to personal possessions while traveling or en route at a hotel or other facility)		
<b>Other (please specify)</b>		

<input type="checkbox"/>	All brochures available to Renters that describes the coverage you offer.	<input type="checkbox"/>	The training program materials
<input type="checkbox"/>	The Consumer Disclosure required by § 10-604 of the Maryland Code and Maryland Regulations, COMAR 31.03.11 (Indicate Disclosure type below)		

<input type="checkbox"/>	<b>Written</b>	If written a copy of all written materials containing the disclosure must be filed for approval of the Commissioner.
<input type="checkbox"/>	<b>Oral</b>	If oral for telephone sales, the text of the disclosure must be filed for approval of the Commissioner.
<input type="checkbox"/>	<b>Electronic</b>	If an electronic disclosure, provide the Commissioner with access to the electronic web site and file a print out of each screen that contains the disclosure for approval of the Commissioner.

**5. VIATICAL SETTLEMENT APPLICANTS ONLY**

Give the full name, address, telephone number, and e-mail address of the **Agent for Service or Process** appointed by the Applicant.

<b>Name:</b>		<b>NPN:</b>		<b>SSN:</b>	
<b>Address :</b>					
<b>Telephone #:</b>		<b>E-Mail:</b>			

Give the full name, title, address, telephone number, and e-mail address of the person who will be responsible for handling or responding to issues regarding activities in Maryland.

<b>Name:</b>		<b>NPN:</b>		<b>SSN:</b>	
<b>Address :</b>					
<b>Telephone #:</b>		<b>E-Mail:</b>			

Identify all owners, partners, officers, directors, members, and producers or employees authorized to act as Viatical Settlement Broker/Provider.

<b>Name:</b>		<b>SSN:</b>		<b>Producer License #:</b>	
<b>Name:</b>		<b>SSN:</b>		<b>Producer License #:</b>	

**6. THIRD PARTY ADMINISTRATOR APPLICANTS ONLY**

Does the Business Entity applying for this registration have liability insurance? If yes, enter the insurer name and policy number below.

<b>Insurer Name:</b>		<b>Policy Number:</b>	
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A Third Party Administrator must have an individual acting as the principal for the TPA. The principal will be the main point of contact between the TPA and the Maryland Insurance Administration. Please provide the principals demographic information below.

<b>Full Name:</b>		<b>Title:</b>		<b>SSN:</b>		<b>% of ownership</b> _____
<b>Address:</b>						

If the principal has any ownership interest or affiliation to any plan which the applicant provides services as an administrator, list the name and address for the sponsor(s) or insurer(s) and a description of the TPA principal's interest or affiliation.

<b>Name:</b>		<b>Phone:</b>		<b>Fax:</b>	
<b>Address:</b>					
<b>Affiliation Description:</b>					

**6. THIRD PARTY ADMINISTRATOR APPLICANTS ONLY (CONTINUED)**

Applicants applying for a TPA registration must submit an original surety bond with the application and supplement. The amount of the surety bond must be determined using the worksheet provided below. After completing the worksheet enter the Surety Bond Information in the space provided.

- a) The surety bond may not be less than 10% of the average amount of funds the administrator expects to handle at any one time for all the plans expected to be administered by the administrator during the coming year, and
- b) The surety bond may not be less than \$5,000 nor more than \$500,000.
- c) The Commissioner may set the amount of the surety bond in excess of \$500,000 up to 10% of the average amount of funds the administrator expects to handle at any one time for all the plans to be administered by the administrator during the coming year.
- d) Subject to approval of the Commissioner, the surety bond may be (1) an individual surety bond, or (2) a blanket surety bond that covers a group or class.

<b>1. Amount of funds handled during the immediately preceding calendar year:</b>	
<b>2. Amount of funds expected to be handled by the administrator during the current calendar year:</b>	
<b>3. (1) divided by 12:</b>	
<b>4. (2) divided by 12:</b>	
<b>5. Greater of (3) or (4):</b>	
<b>6. 10% of (5) = Bond amount (may not be less than \$5,000 nor more than \$500,000)</b>	

<b>Bond Insurance Company Name:</b>			
<b>Bond Number:</b>		<b>Bond Issue Date:</b>	

If the entity has ever been affiliated with an insurer or plan sponsor which was unable to meet its claim or other financial obligations on a current basis from the assets of the plan please provide a detailed explanation below. (Attach additional sheets if necessary)

If the entity has a written executed agreement(s) with the insurer(s) or plan sponsor(s), please provide the name and address of each insurer or plan sponsor below. Include execution and termination date(s). (Attach additional sheets if necessary)

<b>Insurer/Plan Sponsor Name:</b>		<b>Execution Date:</b>	
<b>Address:</b>		<b>Termination Date:</b>	
<b>Insurer/Plan Sponsor Name:</b>		<b>Execution Date:</b>	
<b>Address:</b>		<b>Termination Date:</b>	

If the entity has any written agreement(s) with the insurer or plan sponsor(s) that do not assume or bear the risk please list the name(s) and address(es) of the ultimate risk bearers below. (Attach additional sheets if necessary)

<b>Name:</b>	
<b>Address:</b>	
<b>Name:</b>	
<b>Address:</b>	

**7. APPLICATION CERTIFICATION - ALL APPLICANTS**

I HEREBY CERTIFY that this application has been examined by me. To the best of my knowledge and belief it is a correct and complete statement made in good faith. I understand that any false information may be subject to criminal process and will be grounds for administrative disciplinary action. I understand that all information on this application form executed by me will become public record pursuant to Maryland Insurance Law. I also hereby state that I am familiar with the laws of Maryland concerning rebating, twisting, and commingling of premiums and the embezzlement or fraudulent conversion of insurance premiums.

APPLICANT or AUTHORIZED SUBMITTER FULL NAME (PRINT): \_\_\_\_\_ DATE: \_\_\_\_\_

APPLICANT or AUTHORIZED SUBMITTER SIGNATURE: \_\_\_\_\_