Maryland Insurance Administration
Attn: Producer Licensing Unit, 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202

PRODUCER LICENSING ADVISORY BOARD APPLICATION

- Pursuant to Section 10-110 of the Insurance Article, the Maryland Insurance Commissioner is seeking to appoint advisory board members to assist the Commissioner in reviewing continuing education courses, examinations and other matters relating to the education and qualification of producers.
- Each member of either advisory board, Life/Health or Property/Casualty, shall be experienced in the applicable line of insurance and be either a licensed insurance producer or an employee or officer of an insurer.
- The term of a member of either advisory board is 4 years. A member will not receive compensation, but, if authorized by the Commissioner, may be reimbursed for expenses under the Standard State Travel Regulations.

Full Name of Applicant: _____

Email Address: _____ Employer: _____

Address: _____

City: _____ State: _____ Zip: _____ Daytime Phone: _____

Advisory Board Type (check all that apply):

☐	**LIFE / HEALTH ADVISORY BOARD**
☐	**PROPERTY / CASUALTY ADVISORY BOARD**

Area of Expertise (check all that apply):

☐	**LIFE**		**PROPERTY**		**CASUALTY**
☐	**HEALTH**		**TITLE**		**PERSONAL LINES**

All applicants must attach the following: (please check indicating documents are attached)

☐	A description of the duties the producer/employee has been responsible for in the line(s) of insurance listed above. A "Responsible Duty," is a duty that would result in the applicant becoming reasonably familiar with the basic policy forms, fundamental procedures, and practices for the line(s) selected.
☐	Attach a brief description and copies of membership cards or letters for any insurance society designations or certifications held. (**IF APPLICABLE**)
☐	Attach employment history for the last 10 years detailing employer name, position held, duties, and employment start and end dates.

Type of Experience:

☐ **Licensed Insurance Producer**

Maryland License Number: _____ License Issue Date: _____ License Expire Date: _____

Business Entity Affiliations (List Entity License Number(s): _____ _____ _____

☐ **Insurer Employee / Officer**

Employer Name: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Position Held: _____Employment Start Date: _____ Employment End Date: _____

Employment Verification Contact Name: _____Contact Title: _____

Contact Phone #: _____ Contact Fax #: _____ Contact E-Mail Address: _____

I certify that there is no conflict of interest that would impact my ability to serve in this capacity. "Conflict of Interest," means that because of other activities or relationships with other persons or entities, a person is unable or potentially unable to render impartial assistance or advice to the State, or the person's objectivity in performing the work is or might be otherwise impaired, or a person's involvement will give another person or entity an unfair competitive advantage.

_____ _____

Signature of Producer Date

State of_____ City/ County of _____

On this _____ day of _____, _____, personally appeared before me the said named _____ known to me to be the person described in and who executed the foregoing instrument, and he/she acknowledges the same and, being duly sworn by me, made oath that the statements in the application are true.

_____
Notary Public

My commission expires: _____