south dakota department of labor and regulation

Division of Insurance
445 E. Capitol Ave., Pierre, SD 57501
Tel: 605.773.3563
Fax: 605.773.5369
dlr.sd.gov/insurance

THIRD PARTY ADMINISTRATOR (TPA) APPLICATION FORM

Life/Health ☐ Workers Compensation ☐

1. Full name of Administrator: _____

2. Federal Employee ID: _____

3. Resident State: _____

4. Mailing Address: _____
PO BOX/STREET ADDRESS
_____ _____ _____
CITY STATE ZIP CODE

5. Business Address: _____
PO BOX/STREET ADDRESS
_____ _____ _____
CITY STATE ZIP CODE

6. Business Telephone Number: _____

7. Business Fax Number: _____

8. Contact Person Regarding Application: _____

9. Email Address: _____

10. Aliases:

11. **Pursuant to SDCL 58-29D-29**, if you currently have a valid license as a Third Party Administrator in any other state which has standards at least as stringent as those contained in South Dakota, you may request that your license requirements be waived in South Dakota.

Do you wish to waive license requirements? Yes ○ No ○

12. Are you, your firm, corporation or any of your representatives currently licensed as a resident or non-resident South Dakota agent? Yes ◯ No ◯

If yes, list full names and social security numbers: (Use separate sheet of paper if necessary).

13. Have you, your firm, corporation or any of its officers or directors or any of your representatives, ever been fined, had an insurance license suspended, been denied a license or been subject to any other administrative action by any state, or been convicted of or plead guilty or nolo contendere to any misdemeanor or felony or been terminated for cause by any insurer?
Yes ◯ No ◯

If yes, a detailed explanation with pertinent documentation must be submitted.

14. Does your firm exclusively provide services to one or more bona fide employee benefit plans, each of which is established by an employer or employee organization, or both, and for which the insurance laws of this state are preempted pursuant to the Employee Retirement Income Security Act (ERISA) of 1974? Yes ◯ No ◯

15. Do you wish to apply for annual registration with the director based on the Employee Retirement Income Security Act (ERISA) of 1974 exemption pursuant to SDCL 58-29D-27? Yes ◯ No ◯

If yes, list all employers for which your firm provides Third Party Administrator services in this state. Please include the full name and address of each employer. Use separate sheet of paper if necessary:

16. Are you a Pharmacy Benefits Manager? Yes ◯ No ◯

If yes, this application is not acceptable to be licensed or registered in our state.

THIS APPLICATION SHALL BE VERIFIED AND SIGNED BY AT LEAST TWO OFFICERS OF THE ADMINISTRATOR

_____
Signature of Officer

_____
Typed/Printed Name

_____
Date

_____
Signature of Officer

_____
Typed/Printed Name

_____
Date