ARKANSAS INSURANCE DEPARTMENT
1200 WEST THIRD STREET
LITTLE ROCK, AR 72201
PHONE: 501-683-4170
Website www.insurance.exchange@arkansas.gov

ARKANSAS HEALTH CONNECTOR LICENSE RENEWAL FORM

CHECK LICENSE TYPE: _____ Exchange Producer _____IPA,
_____CAC _____Navigator

Enclosed Fees: Renewal Fee $35.00

Name _____ License # _____
Last First Middle Initial

Current Mailing Address: _____
P.O. Box or Street Number City State Zip

Current Business Address: _____
P.O. Box or Street Number City State Zip

Current Residence Address: _____
Street Number City State Zip

Home Phone Number: _____ Business Phone Number: _____ Fax # _____

E-Mail Address: _____

THESE QUESTIONS MUST BE ANSWERED: If you answer yes, you must attach to this renewal form (a) a written statement explaining the circumstances of each incident, (b) a copy of any legal notice and (c) a copy of the official documentation showing the resolution or final judgment.

1. Have you been convicted of or currently charged with a crime (whether or not adjudication was withheld) since the last renewal of this license? [_] Yes [_] No
2. Have you or any business in which you are or were an owner, partner, officer, or director or any business in which you are or were an owner, partner, officer or director been involved in an administrative proceeding regarding any professional or occupational license since the last renewal of this license? [_] Yes [_] No
3. Has any demand been made or judgment rendered against you for overdue monies by an insurer, insured, or producer since you last renewed this license? [_] Yes [_] No
4. Have you been subject to a bankruptcy proceeding since you last renewed this license? [_] Yes [_] No
5. Have you been notified by any jurisdiction of any delinquent tax obligation [_] Yes [_] No
   a) If yes, do you have a repayment agreement [_] Yes [_] No
6. Since your last renewal, are you a party to, or have you been found liable in, any lawsuit or arbitration proceeding involving allegations of fraud, misappropriation or conversion of funds, misrepresentation or breach of fiduciary duty? [_] Yes [_] No
7. Do you have a child support obligation in arrearage? [_] Yes [_] No
   If you answer yes to Question 7,
   a)By how many months are you in arrearage? _____Months
   b)Are you currently subject to a repayment agreement: [_] Yes [_] No
   c)Are you the subject of a child support related subpoena/warrant? [_] Yes [_] No

I hereby certify that, under penalty of perjury, all of the information submitted in this application and attachments is true and complete. I am aware that submitting false information or omitting pertinent or material information in connection with this application is grounds for license revocation or denial of the license renewal and may subject me to criminal penalties.

SIGNATURE: _____ DATE: _____
(Wet ink signature is required---Do not use stamped signature)

MAKE MONEY ORDER PAYABLE TO THE ARKANSAS INSURANCE DEPARTMENT TRUST FUND. **Payment must be, money order or cashier's check---NO PERSONAL OR BUSINESS CHECKS ACCEPTED-**
PLEASE MAIL PAYMENTS AND THE COMPLETED FORM to the attention of the AR HEALTH CONNECTOR DIVISION at the address listed above.