



**ARKANSAS INSURANCE DEPARTMENT
LICENSE DIVISION
1200 WEST 3RD STREET
LITTLE ROCK, AR 72201
PHONE: 501-371-2750
FAX: 501-683-2604**

**INSTRUCTIONS FOR REGISTRATION OF SELF-FUNDED SINGLE
EMPLOYER PLANS, COLLECTIVELY BARGAINED WELFARE
BENEFIT PLANS, MUTIPLE EMPLOYER TRUSTS AND
MULTIPLE EMPLOYER WELFARE ARRANGEMENTS
(Ark. Code Ann. § 23-92-101)**

1. Complete form AID-LI-SELF
2. For Multiple Employer Trust and Multiple Employer Welfare Associations, a full copy of the trust agreement must be attached to the form.
3. A detailed written explanation of the basis for the enrollment in the Multiple Employer Welfare Association or enrollment in the Multiple Employer Trust must be attached to the form.
4. If the plan is registered in other states than Arkansas, complete question #6 and attach copies of all licenses or registrations for those other states.
5. Attach copies of any and all marketing materials that will be used in Arkansas.
6. Attach a list of all producers, agents, brokers, consultants or adjusters who will be transacting or processing business for the plan in the State of Arkansas. This list must include the name, address, phone number and license number of the licensee.
7. If the Plan is fully insured a copy of the declaration page/certification and policy must be attached to the application.
8. Multiple Employer Trusts and Multiple Employer Welfare Associations and Self Funded Plans must attach complete copies of any and all filings made to the Department of Labor and/or the Internal Revenue Service within the last 12 months from the date of application.



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**SELF-FUNDED SINGLE EMPLOYER PLANS,
COLLECTIVELY BARGAINED WELFARE BENEFIT PLANS,
MULTIPLE EMPLOYER TRUSTS AND MULTIPLE
EMPLOYER WELFARE ARRANGEMENTS
(Ark. Code Ann. § 23-92-101)**

1. Name of Plan: _____
2. Tax ID Number of Plan: _____
3. Address of Plan: _____
4. Contact Name and Title _____ Telephone No. _____
5. Type of Plan, Arrangement, Association or Trust:
 - Self -Funded Single Employer Plan
 - Collectively Bargained Welfare Benefit Plan (Taft-Hartley Trust)
 - Multiple Employer Trust
 - Fully Insured Multiple Employer Welfare Arrangement
 - Not Fully Insured Multiple Employer Welfare Arrangement
6. List all States in which the Plan is registered or licensed (attach copies of license/registration to this form):

7. List all States in which the Plan is doing business or covers individuals:

8. Has the Plan had any complaints regarding claim payment in other states: Yes No
(If yes, attach a copy of the documentation of the complaint and documentation of the resolution of the complaint)
9. Third Party Administrator: Name _____
Federal Tax ID _____ Address _____
Contact Name and Title _____ Tel. No. _____

10. Number of Individual Arkansas Residents Covered by the Plan or Arrangement _____

11. If a fully insured multiple employer welfare arrangement or trust, state name, address and telephone number and the NAIC number of the disability or health insurer underwriting the plan: *(A copy of the declaration page/ certificate and policy must be attached to this application.)*

Name of Company _____ NAIC No. _____

Contact Name and Title _____ Tel. No. _____

12. If a multiple employer welfare arrangement or trust which is not fully insured, state name, address and telephone number of person(s) administering the plan, whether or not a third party administrator.

Name of Administrator _____

Address of Administrator _____

Contact Name and Title _____ Tel. No. _____

AFFIDAVIT

I, the undersigned, do hereby swear or affirm under oath that the information submitted above is true and accurate to the best of my knowledge and belief.

Name and Title _____ Date _____

State of _____

County of _____

Subscribed to and sworn or affirmed before me on this _____ Day of _____, 20____.

My Commission Expires: _____

Seal

Notary Public