



# STATE OF MAINE Bureau of Insurance

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## Third Party Administrator License Application

A \$100 LICENSE FEE IS DUE WITH YOUR APPLICATION  
--Please Make Payable to Treasurer State of Maine--

*NOTE: Foreign, Foreign Limited Partnerships, Limited Liability Companies, or Limited Liability Partnerships (Title 31 §852) may also be required to apply to the Maine Secretary of State for authority to do business in the State of Maine. See Secretary of State website for additional information. <http://www.maine.gov/sos/cec/corp/foreign.html>*

1. Name of applicant company:			
2. D.B.A. (if applicable) -- Please list all used. Use separate sheet if necessary--			3. Federal ID#:
4. Principal address: (including City, State, Zip)		5. Address where records are kept: (including City, State, Zip)	
6. State Incorporated in:	7.* Bond carrier:	8. Bond amount:	9. Bond number:
10. Mailing Address: (for billing & correspondence)		11. Contact Person/Title:	12. Direct Phone & Email:
13. Is the applicant licensed in any other state to perform similar service? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list state(s) and license number, etc. <u>Label as Exhibit A.</u>			
14. Attach a list of all officers, directors, partners (if applicable) and controlling persons, and positions held. <u>Label as Exhibit B.</u> A. "Directors" refers to board of directors; executive committee or other governing board as applicable. B. "Controlling persons" refers to ultimate ownership or control as defined in Title 24-A M.R.S.A. §222.			
15. Do you handle premium payments?  <input type="checkbox"/> Yes <input type="checkbox"/> No	16. Do you handle money on behalf of a plan sponsor, insurer, or other entity providing benefits?  <input type="checkbox"/> Yes <input type="checkbox"/> No	17. Do you adjust claims?  <input type="checkbox"/> Yes <input type="checkbox"/> No	18. Do you pay claims?  <input type="checkbox"/> Yes <input type="checkbox"/> No
19. Line of business services are provided for: <input type="checkbox"/> Life <input type="checkbox"/> Annuity <input type="checkbox"/> Health <input type="checkbox"/> Workers Compensation (check all that apply)			
20. Attach a list of each program in the State of Maine for which you provide TPA services. Identify each program by the following: 1) name of plan sponsor and any affiliations, 2) name of company(ies) receiving services, 3) type of service performed, 4) type of business being serviced (indicate whether self-insured or fully insured plan) 5) the line(s) of business from above that is provided for each plan. <u>Label as Exhibit C.</u>			
21. Describe all fiduciary accounts maintained (type of account, purpose of account, parties to the account) and indicate institution where account is held. <u>Label as Exhibit D.</u>			
22. Complete bond calculation on back and submit required bond with application.			

**Bond Calculation: (Based on projections for following year)**

***~For Maine Business Only~***

- A. Premiums collected/received     \$ \_\_\_\_\_
- B. Claims paid                             \$ \_\_\_\_\_
- C. Sum A & B                                 \$ \_\_\_\_\_
  
- C x .05 (5%)     \$ \_\_\_\_\_

Necessary bond amount = the greater of \$50,000 or 5% of A+B. 24A § 1904. Bond requirements for administrators

\_\_\_\_\_  
Signature of Principal Officer

\_\_\_\_\_  
Type or Print Name of Principal Officer

\_\_\_\_\_  
Title

IN WITNESS WHEREOF, the said company has affixed its seal and caused this application to be signed by the principal officer and/or Attorney-in-Fact on this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_.

**\*NOTE: Please provide the State of Maine with an *original* Bond**

*Example for item 20:*

Plan Sponsor: ABC Nursing Association

Affiliation with sponsor: Part of Same Group, Sister Company, Parent Company, Subsidiary Company, Not affiliated

Company(ies) Receiving Services: DEF Nursing Care, GHI Home Health Services, and ZYX Home Nursing Assistance

Type of Services Performed: Collection of premiums, Claims adjustment, Payment of Claims –or– a brief description of process if none of these are a good fit.

Line(s) of Business: DEF Nursing Care: Life, Health, Workers Compensation, Annuity

GHI Home Health Services: Workers Compensation

ZYX Home Nursing: Annuity, Life

*Example for item 21:*

Type of Account: Administrative Trust Fund (ATF), Claims Administrations Services Account (CASA)

Purpose of Account: for contributions and premiums or for claims and claims adjustment expense disbursements.

Parties to the Account: Plan sponsor, TPA, both, etc.