



INSTRUCTIONS FOR ANNUAL REPORT FOR A PHARMACY SERVICES ADMINISTRATIVE ORGANIZATION IN THE STATE OF LOUISIANA

GENERAL INSTRUCTIONS

This packet is designed to assist the individual preparing the annual report in complying with our requirements and procedures. The forms and procedures of the reporting process are designed to facilitate our review of the report. Therefore, it is extremely important that all pharmacy services administrative organization comply fully with the instructions and requirements set forth in this packet. This annual report form should be used for reporting of information for pharmacy services administrative organizations pursuant to La. R.S. 22:1660.3.

All communication should be directed to:

Louisiana Department of Insurance
Company Licensing Division
P.O. Box 94214
Baton Rouge, LA 70804-9214
Phone: (225) 342-1251
Fax: (225) 219-9322
E-Mail Address: companyapps@ldi.la.gov

While our Department will be happy to assist you and answer any questions you may have, we ask that you thoroughly review all instructions and forms before contacting us.

- 1) Annual reports must be post-marked no later than March 1 of the year due.
- 2) The information contained in the annual reports is for the year ended December 31 of the year previous to the filing. While information subsequent to December 31 may be filed with the annual report the report itself should only include information up to the deadline of December 31.
- 3) All submittals in association with this report must reach us via the United States Postal Service or a carrier with interstate business. Hand delivery is not acceptable and any information arriving in this manner will be returned without review. In addition, all correspondence must be sent to the attention of the Company Licensing Division to assure prompt receipt and handling.
- 3) Submit only a fully completed report. Submittal of a partially completed report will cause processing delays and may result in rejection of the report.
- 4) **Do not alter** the forms contained in this packet. If you feel the requirements do not apply to your situation, notify us. We will supply the proper form, if appropriate, and/or answer any questions you have about the forms.
- 5) All original items submitted become the property of the Louisiana Department of Insurance and **will not be returned**.

- 6) All entries in the report forms must be typed or printed. Illegible entries or responses will be considered incomplete and may result in the rejection of the report.
- 7) When designating a contact person, please remember that all correspondence from our Department will be directed to this individual. Therefore, please choose a person who will be able to respond to most inquiries or direct them to the appropriate person for response. We must be notified in writing of any change in the contact person during the course of the year.
- 8) The annual report is intended to comply with the provisions of La. R.S. 22: 1660.2G. La. R.S. 22:1660.2G requires a licensed pharmacy service administrative organization shall notify the commissioner if there is any material change in fact or circumstance affecting its qualification for license in this state.
- 9) If, for some reason, an item which would otherwise be required is not available, a written explanation must be supplied upon submission.
- 10) It is the responsibility of the PSAO to ensure that none of the responses and submittals in association with this report conflict with the information filed with the domiciliary state. Conflicting information may result in regulatory action.

SPECIAL INSTRUCTIONS FOR ATTESTATION PAGE

Each annual report packet includes an attestation page.

The signatures which appear on the attestation page are determined by the legal structure of the pharmacy services administrative organization. Below are the expected variations and the instructions for who should sign the application in each case.

IF THE APPLICANT IS A(N)...	THE APPLICATION SHOULD BE SIGNED BY...
Individual	the applicant
Corporation	any two officers
Association	any two officers
Partnership	two partners
Trust	two trustees
Any other	contact the Department for instructions

COMMON QUESTIONS

The following are some of the most commonly asked questions regarding the PSAO annual report process.

Q: Where can I find the laws and regulations for pharmacy services administrative organizations in Louisiana?

A: Title 22 of the Louisiana Revised Statutes is the Louisiana Insurance Code (the Code) and most laws enacted by the Louisiana Legislature which affect pharmacy services administrative organizations can be found in that Title. The portions of the Code dealing specifically with pharmacy services administrative organizations are La. R.S. 22:1660.1-1660.9. The statute which addresses fees payable in association with pharmacy services administrative organizations annual report fee is La. R.S. 821(39).

Q: Will I be notified of the acceptance of my report?

A: Each PSAO will be notified of the acceptance of the annual report. This notification or a request for additional information can be expected to take thirty (30) to sixty (60) days from our receipt of the report. Please take this time frame into account when considering deadlines and operation schedules for the PSAO.

Q: Can the forms in the report packet be recreated on a word processor for completion by the applicant?

A: No. The forms in this packet are designed for ease of recognition by our staff and, in many cases, in strict compliance with statutory wording requirements. Therefore, any changes in the format or wording of the forms will cause delays in the review and may lead to the rejection of the report. The forms are made available on our web site in a format that allows for entry of information directly onto the form.

Q: We were not licensed as an PSAO in Louisiana until late in the year. Are we still required to file an annual report?

A: All PSAOs licensed on or before December 31, of the reporting year must file an annual report for that year.

Q: What is the penalty for failure to file the annual report on or before the due date?

A: Pursuant to LRS 22:1660.4 the commissioner may suspend or revoke the license of the pharmacy services administrative organization which violates any provision of the insurance laws of this state and may be fined up to \$500.00 per violation.

Q: Must the reports be bound when they are returned?

A: No. The reports are not required to be bound in any way when they are returned to this Office.

Q: If a PSAO wishes to surrender its license or otherwise cease doing business in Louisiana, can this be accomplished by not filing the annual report?

A: No. The annual report is a report, not a renewal. If a PSAO wishes to surrender its license, they may do so by returning the license with the annual report but any PSAO licensed on December 31 is responsible for the annual report for the preceding year.



LOUISIANA DEPARTMENT OF INSURANCE
TIMOTHY J. TEMPLE
COMMISSIONER

**ANNUAL REPORT FOR A
PHARMACY SERVICES ADMINISTRATIVE ORGANIZATION
IN THE STATE OF LOUISIANA**

General Information (Type or Print)
PSAO NAME: _____
TRADE NAME: _____
FEI OR SOCIAL SECURITY NO.: _____ DOMICILE: _____
HOME OFFICE ADDRESS: _____ _____ _____
CONTACT NAME: _____ CONTACT TITLE: _____
PHONE: _____ FACSIMILE: _____
CONTACT ADDRESS: _____ _____ _____
E-MAIL: _____

FEES	
Annual Report Fee = \$150.00	<u>\$ 150.00</u>
Make all checks payable to the Louisiana Department of Insurance	Total Amount This Check <u>\$150.00</u>

SECTION 2 – ADDRESS AND CONTACT INFORMATION

DOMICILE ADDRESS: Below give the domiciliary (registered office) address of the PSAO.		
Address:		
City:	State:	Zip:

MAILING ADDRESS: Below give the mailing address of the PSAO.		
Address:		
City:	State:	Zip:

ADMINISTRATIVE OFFICE ADDRESS: Below give the physical address of the main administrative office of the applicant.		
Address:		
City:	State:	Zip:

BOOKS AND RECORDS LOCATION: Below give the physical address where the books and records of the PSAO are available for inspection by the Louisiana Commissioner of Insurance.		
Address:		
City:	State:	Zip:

COMPLAINT CONTACT: Below give the name, address, phone number and email address for the contact person to whom consumer complaints should be directed.		
Name:		
Address:		
City:	State:	Zip:
Phone Number:	Email Address:	

SECTION 2 – ADDRESS AND CONTACT INFORMATION - Continued

CONTACT PHONE NUMBERS Below give the appropriate phone number for the indicated function. If the PSAO has designated numbers for specific functions, include that information below.	
FUNCTION	PHONE NUMBER
Primary Phone Number of PSAO	
General Consumer Inquiries	
Other (explain) _____	
Other (explain) _____	
Other (explain) _____	

WEB ADDRESS: If the applicant maintains a web site, give the URL or World Wide Web address of the site.

SECTION 3 - INTERROGATORIES

Answer all of following questions. ATTACH A FULL EXPLANATION AND THE REQUESTED INFORMATION FOR ANY "YES" ANSWERS. However, if the PSAO has previously supplied the requested information previously to the LDOI and there are no supplemental documents or explanations to what was previously supplied, you may incorporate the previous explanation by reference herein.

<p>1) Has the PSAO made any changes to its Articles of Incorporation, Articles of Association, Partnership Agreement, bylaws, rules, regulations, or other such organizational documents which have not been filed with this Department? (If yes, provide a copy of the amended document certified by the proper domiciliary state official.)</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<p>2) Has the PSAO made any changes to its operating practices which would invalidate or make obsolete the plan of operation filed with this Department? (If yes, please supply an amended plan of operation.)</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<p>3) Are there any persons responsible for the conduct of affairs of the administrator, including all officers*, all directors, all partners (in the case of a partnership), all trustees, all executive committee members and all person(s) owning, directly or indirectly, 10 percent or more of the administrator and any other person who exercises control or influence over the affairs of the administrator, for whom biographical affidavits have not been filed with this Department? (If yes, submit completed biographical affidavits for each such person and the effective date of the election/appointment of this person.)</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<p>4) Is the PSAO part of an insurance holding company group? (If yes, provide the holding company group code assigned by the NAIC. _____)</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<p>5) Has the PSAO ever had an application denied by any state or federal regulatory authority? (If yes, provide details including the type of application, the identity of the authority which issued the denial, the reasons for the denial and an explanation of any subsequent events.)</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<p>6) Has the PSAO or any entity which is affiliated or under the same general management, interlocking directorate or ownership as the administrator ever had a Certificate of Authority or license suspended or revoked by any regulatory authority? (If yes, provide details including the type of action, the identity of the authority that took the action, the reasons for the action, a copy of the order or other such notice of the action and an explanation of any subsequent events.)</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<p>7) Has the PSAO ever been subject to any regulatory action including cease and desist orders, fines, consent agreements or similar actions? (If yes, provide details including the type of action, the identity of the authority that took the action, the reasons for the action, a copy of the order or other such notice of the action and an explanation of any subsequent events.)</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<p>8) Has the PSAO ever been placed into any type of regulatory supervision or rehabilitation by any regulatory authority? (If yes, provide details including the type of action, the identity of the authority that took the action, the reasons for the action, a copy of the order or other such notice of the action, an explanation of any subsequent events and an explanation of the current status.)</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<p>9) Within the last two years, has the applicant undergone a change in ownership (direct or indirect) of 10 percent or more? (If yes, provide a full explanation of the change in ownership and an organizational/ownership chart which clearly shows the ownership of the applicant both before and after the transaction.)</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<p>10) Is the PSAO part of an insurance holding company group? (If yes, provide the holding company group code assigned by the NAIC _____.)</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<p>11) Does this PSAO have any agreements with pharmacist or pharmacies in the state of Louisiana? If yes, please provide the number of agreements _____.</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO

SECTION 4 - LIST OF MANAGEMENT AND OWNERS

Below give the full legal name (no initials), resident address, position with the applicant and the percentage of ownership (if applicable) of all natural persons responsible for the conduct of affairs of the applicant. This list should include all officers, all directors, all partners (in the case of a partnership), all trustees, all executive committee members and every natural person owning, directly or indirectly, 10 percent or more of the applicant and any other natural person who exercises control or influence over the affairs of the applicant.

NAME:			
STREET:	CITY:	STATE:	ZIP:
POSITION:		OWNERSHIP %:	
NAME:			
STREET:	CITY:	STATE:	ZIP:
POSITION:		OWNERSHIP %:	
NAME:			
STREET:	CITY:	STATE:	ZIP:
POSITION:		OWNERSHIP %:	
NAME:			
STREET:	CITY:	STATE:	ZIP:
POSITION:		OWNERSHIP %:	
NAME:			
STREET:	CITY:	STATE:	ZIP:
POSITION:		OWNERSHIP %:	
NAME:			
STREET:	CITY:	STATE:	ZIP:
POSITION:		OWNERSHIP %:	
NAME:			
STREET:	CITY:	STATE:	ZIP:
POSITION:		OWNERSHIP %:	

ATTESTATION

STATE OF _____

COUNTY OR PARISH OF _____

BEFORE ME, the undersigned authority, personally appeared _____

as an authorized representative of _____,

who, after being duly sworn, did depose and state that all information contained in this annual report and all attachments thereto are, to the best of his/her knowledge, true, complete and correct.

Signature of Witness

Signature of Executive Officer or Other Comparable
Responsible Person

Printed Name of Witness

Printed Name and Title or Position of Signatory

Signature of Witness

Signature of Executive Officer or Other Comparable
Responsible Person

Printed Name of Witness

Printed Name and Title or Position of Signatory

SWORN TO and subscribed before me this _____ day of _____, 20 ____.

Signature of Notary

Printed Name of Notary

NOTARIAL SEAL

My Commission Expires _____