COMMONWEALTH OF MASSACHUSETTS
Office of Consumer Affairs and Business Regulation
DIVISION OF INSURANCE
1000 Washington Street, Suite 810 • Boston, MA 02118-6200
(617) 521-7794 • FAX (617) 521-7475
TTY/TDD (617) 521-7490
https://www.mass.gov/orgs/division-of-insurance

Application for Registration as a Third-Party Administrator in the Commonwealth of Massachusetts as Required by 211 CMR 148.00

To: The Office of the Commissioner of Insurance

Application is hereby made for registration as a Third-Party Administrator ("TPA") pursuant to 211 CMR 148.00, and in support thereof, the following information and documentary evidence is submitted for review:

[1] TPA Information:
TPA Name: _____
TPA Address: _____
_____
TPA Telephone Number: (___) _____
TPA Tax ID number (FEIN): _____

[2] Verify that your organization "receives or collects charges, contributions or premiums for, or adjusts or settles claims **on or for residents of the Commonwealth of Massachusetts** for persons who may be covered under health benefit plans for your organization's clients self-insured customers" as defined under 211 CMR 148.00. _____

[3] Verify that your organization has forwarded to the Division of Insurance, each April 1, the annual report required under 211 CMR 148.04 that includes, among other items, (1) details about claims information that you may be processing **on or for residents of the Commonwealth of Massachusetts** and (2) information about Massachusetts mandated benefits that are being covered in the self-funded benefit plans that you are administering **for Massachusetts-based accounts.** _____

[3a] Identify for this application the number of Massachusetts residents covered under accounts that are being administered by your organization as of December 31 of the most recently completed calendar year _____

[3b] Identify for this application the number of Massachusetts-based employer accounts that are being administered by your organization as of December 31 of the most recently completed calendar year _____

[4] TPA Contact Person Information:
TPA Contact Person Name: _____
TPA Contact Person Telephone Number: (___) _____
TPA Contact Person E-mail Address: _____

[5] Verify that the above named person is the correct contact at your company to receive information and communications regarding the annual report that is required pursuant to 211 CMR 148.04: _____

[6] Provide a narrative description of the TPA and its activities: _____

_____

_____

[7] State in which the TPA has been formed: _

[8] State in which the TPA is headquartered: _

[9] State(s) in which the TPA operates: _____

_____

_____

[10] Provide copies of the basic organizational documents of the TPA, including any articles of incorporation, articles of association, partnership agreement, trade name certificate, trust agreement, shareholder agreement and other applicable documents and all amendments to such documents.

[11] Provide a copy of the bylaws, rules, regulations or similar documents regulating the internal affairs of the TPA.

[12] Provide a list of the services, other than those related to the receipt or collection of charges, contributions or premiums for, or adjustment or settlement of claims, on or for residents of the Commonwealth, that the TPA offers to self-insured customers.

[13] Is the TPA managing the solicitation of new or renewal business on behalf of a Health Insurer? □ Yes □ No
If yes, provide proof that the TPA employs or has contracted with an insurance producer licensed in the Commonwealth for the solicitation and taking of applications.

[14] Is the TPA intending to directly solicit insurance contracts or otherwise act as an insurance producer? □ Yes □ No
If yes, provide proof that the TPA is a licensed insurance producer in the Commonwealth.

[15] Verify that your organization does not only administer claims data, eligibility data, provider files and other information for its own employees and dependents, since such an organization is exempt from the Division's regulation. _____

A TPA must report any material changes to the information contained in this Application, certified by an officer of the TPA, within 30 days of such changes.

Any questions regarding this application should be directed to tpa.mailbox@mass.gov.

Applicant's Certification

I have reviewed the materials that are being submitted by the applicant to the Massachusetts Division of Insurance and I now state that they are correct, accurate and complete to the best of my knowledge.

_____ _____
Signature Date

NO FEE IS DUE WITH THIS APPLICATION
Mailing address:
Massachusetts Division of Insurance
Health Care Access Bureau
1000 Washington Street Suite 810
Boston, MA 02118-6200