



**EXEMPTION FROM LICENSING:
EMPLOYEE BENEFIT PLAN ADMINISTRATOR**

Ref: Chapter 633, Wis. Stat. Ch. Ins 8, Subch. II, Wis. Adm. Code

INSTRUCTIONS

Fill out the exemption form and send it to P.O. Box 7872, Madison, WI 53707-7872 or email to ociagentlicensing@wisconsin.gov to file for a licensing exemption for an Employee Benefit Plan Administrator license in Wisconsin. Exemption forms are only filed with the Office of Commissioner of Insurance. Confirmation of receipt will be sent to business email and contact email listed on the form within 5 to 10 days.

PLEASE COMPLETE THE BLANKS AND CHECK THE APPROPRIATE BOXES BELOW

Employee Benefit Plan Administrators (EBPA)

Business Entity Name		FEIN	
DBA/Trade Name (if applicable)			State of Domicile
Business Address		City	State Zip
Phone Number () -	Business Email		Incorporation/Formation Date (month) (day) (year)
Mailing Address	P.O. Box	City	State Zip
Contact Person (for questions relating to the application filing)	Email		Phone Number () -
Type of Organization (check one) <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Limited Liability Partnership <input type="checkbox"/> Individual			
Name _____			
National Producer Number (NPN)/Wisconsin License # _____			
Address _____			
P.O. Box _____			
City _____ State _____ Zip+4 _____			

AFFIDAVIT

Check all that apply. If you do not check all three boxes, you will not be eligible for an exemption and licensing will be required.

- The applicant collects only contributions to self-funded employee benefit plans as defined by the Employee Retirement Income Security Act (ERISA) of 1974;
- The applicant does not collect or administer premiums for stop-loss coverage; and
- The applicant does not perform any function with respect to a multi-employer welfare arrangement as defined under ERISA.

CERTIFICATION

I have read and knowingly made the foregoing statements and representations and certify that each statement and representation is true to the best of my knowledge. I understand that any misrepresentation, false statement, or fraud in connection with this form may be cause for administrative actions or penalties or both.

I intend to act in good faith and to comply with all applicable Wisconsin laws and with all applicable rules and orders of the Wisconsin Commissioner of Insurance. I agree to be subject to the jurisdiction of the Commissioner of Insurance and the Wisconsin courts on any matter related to my activities in Wisconsin and to accept service of process under ss. 601.72 and 601.73, Wis. Stat.

Signature of Applicant	Title
Name (Print)	Date

Pursuant to s. 601.72, Wis. Stats. Personal information you provide may be used for purposes other than that for which it was originally collected (s. 15.04(1)(m), Wis. Stats.)