



**NEW YORK STATE INSURANCE DEPARTMENT
LICENSING SERVICES BUREAU
Continuing Education Program
One Commerce Plaza
Albany, New York 12257**

FOR DEPARTMENT USE ONLY
Approval No.: _____
Examined By: _____
Date Approved: _____

AFFILIATE APPLICATION

1.

Name of Affiliate		Taxpayer I.D. Number*	
Address Number and Street (Required)			P.O. Box (if any)
City, Town or Village	County	State	Zip Code

2. List all officers, directors, partners or members and give information requested below:

(A) Name Last	First	M.I.	Title	Director Yes <input type="checkbox"/> No <input type="checkbox"/>	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Date of Birth
No. and Street (Required)		P.O. Box (if any)	City, Town or Village	State	Zip Code	Social Security Number *

(B) Name Last	First	M.I.	Title	Director Yes <input type="checkbox"/> No <input type="checkbox"/>	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Date of Birth
No. and Street (Required)		P.O. Box (if any)	City, Town or Village	State	Zip Code	Social Security Number *

(C) Name Last	First	M.I.	Title	Director Yes <input type="checkbox"/> No <input type="checkbox"/>	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Date of Birth
No. and Street (Required)		P.O. Box (if any)	City, Town or Village	State	Zip Code	Social Security Number *

(D) Name Last	First	M.I.	Title	Director Yes <input type="checkbox"/> No <input type="checkbox"/>	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Date of Birth
No. and Street (Required)		P.O. Box (if any)	City, Town or Village	State	Zip Code	Social Security Number *

(Attach additional sheets, if necessary)

3. If an entity (stock corporation, limited liability company or partnership) give the full name and address of the ten largest principals (stockholders, members or partners) and percentage of ownership or control of/by each:

(1) Name	Last	First	M.I.	Percentage of Ownership or Control: _____ %			
Number and Street (Required)		P.O. Box (If any)		City, Town or Village		State	Zip Code
(2) Name	Last	First	M.I.	Percentage of Ownership or Control: _____ %			
Number and Street (Required)		P.O. Box (If any)		City, Town or Village		State	Zip Code
(3) Name	Last	First	M.I.	Percentage of Ownership or Control: _____ %			
Number and Street (Required)		P.O. Box (If any)		City, Town or Village		State	Zip Code

(Attach additional sheets, if necessary)

4. Has affiliate or any of its officers, directors, partners or members, individually or through connection with a corporation, limited liability company or partnership, other than traffic violations ever:

- (a) Been charged by any governmental agency, insurer, society, employer or others with irregularities of any nature? Yes No
- (b) Compromised liabilities with creditors, been insolvent or adjudged a bankrupt? Yes No
- (c) Been fined, refused a license or had one suspended or revoked by any governmental agency or authority? Yes No
- (d) Any criminal action(s) pending? Yes No
- (e) Been convicted (even if charge was reduced to a violation) in any criminal action? Yes No
- (f) Been denied approval to participate in the Continuing Education Program of any state or had approval withdrawn? Yes No
- (g) Had professional credential(s) revoked, suspended, annulled or denied? Yes No

If answer to (a), (b), (c), (d), (e) or (f) is "Yes," explain: _____

Also, attach Certificate of Court in which the case was tried or a Certificate of Relief from Disabilities if one was issued.

5. Are any of the individuals named in questions 2 or 3 under obligation to pay child support? Yes No

If "YES," attach signed Child Support Obligation Form for each individual under such obligation.

6. Does this Affiliate have an agreement to act under the auspices of any other Continuing Education Provider Organization? Yes No

If "YES," list Provider Organization name(s) and Approval Number(s) below:

_____	_____
Name of Provider Organization	Approval Number
_____	_____
Name of Provider Organization	Approval Number
_____	_____
Name of Provider Organization	Approval Number
_____	_____
Name of Provider Organization	Approval Number

Under the penalties of perjury (I) or (we) affirm that the information given in the foregoing application is true and hereby subscribe thereto.

I have read the Department's Continuing Education Criteria and will comply.

I have attached a copy of the written agreement between the Provider Organization and the Affiliate.

Signature of Affiliate Officer, Director, Partner or Member

Date

Print or Type Above Name

Affiliate Telephone Number

Affiliate Email Address

Affiliate Fax Number

Under the following conditions the Provider Organization must notify the Department immediately in writing:

- a. If this affiliation ceases for any reason whatsoever, or**
- b. If any of the information on this application changes.**

Provider Organization Name	Provider Organization Approval Number
Signature of Provider Organization Designated Person	Date
Provider Organization Telephone Number	Print or Type Above Name

The Provider Organization may NOT conduct business with the Affiliate until the Affiliate Approval Document has been received by the Affiliate from the Insurance Department.

*** * * CHILD SUPPORT NOTIFICATION * * ***

Persons four (4) months in arrears in child support or who have failed to comply with a summons, subpoena, or warrant relating to paternity or child support proceeding may be subject to suspension of their business, professional driver, and/or recreational licenses and permits including, but not limited to, licenses pursuant to § 11-0713 of the Environmental Law.

Intentional submission of false statements for the purposes of frustrating/defeating lawful enforcement of support obligations is punishable under § 175.35 of the Penal Law.

*** * * PRIVACY NOTIFICATION * * ***

Pursuant to Article 1, Section 5 of the New York State Tax Law, it is mandatory that you report your Social Security Number and/or Employer Identification Number. Your failure to respond may be reported to the Department of Taxation and Finance. These tax identification numbers are being collected to enable the Department of Taxation & Finance to identify entities which are delinquent in or have understated their tax liabilities, and may be used for any purpose authorized by the Tax Law. They will be maintained by the Director, Licensing Services Bureau, New York State Insurance Department, One Commerce Plaza, Albany, New York 12257. Telephone: (518) 474-6630.

The New York State Insurance Department will, absent your written objection, which must be attached to this application, provide these tax identification numbers to the National Association of Insurance Commissioners for inclusion in its Producer Database.

CHILD SUPPORT OBLIGATION FORM

Name of Entity on Application (Please Print)

License Number

Name of Individual (Please Print)

Date of Birth

Social Security Number

	YES	NO
Are you under obligation to pay child support?	<input type="radio"/>	<input type="radio"/>
If "YES," (a) Are you less than four (4) months in arrears?	<input type="radio"/>	<input type="radio"/>
(b) Are you paying by income execution plan agreed to by courts or parties	<input type="radio"/>	<input type="radio"/>
(c) Is the obligation subject of pending court proceeding?	<input type="radio"/>	<input type="radio"/>
(d) Are you receiving public assistance or supplemental security income?	<input type="radio"/>	<input type="radio"/>

If answer to the question regarding obligation to pay child support is "YES," one of the answers to (a)-(d) must be "YES" or license will expire six (6) months from the effective date of this license unless you notify the Department by that time which answer has changed to "YES."

Persons four (4) months in arrears in child support or who have failed to comply with a summons, subpoena, or warrant relating to paternity or child support proceeding may be subject to suspension of their business, professional, driver and/or recreational license and permits including, but not limited to, licenses issued pursuant to §11-0713 of the Environmental Conservation Law.

Intentional submission of false statements for purposes of frustrating/defeating lawful enforcement of support obligations is punishable under §175.35 of the Penal Law.

Under the penalties of perjury, I affirm that I have read this form and affirm that the information given on this form is true and hereby subscribe thereto.

Printed Name of Applicant

Signature

Date