



Department of Commerce

COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS

P.O. Box 5795 CHRB, Saipan, MP 96950

Telephone: (670) 664-3000 Fax: (670) 664-3067

Website: <http://commerce.gov.mp/>

OFFICE OF THE INSURANCE COMMISSIONER

Telephone: (670) 664-8018 or 664-8020 Fax: (670) 664-8074

<input type="checkbox"/> NEW 20__	LICENSE FEE \$ _____	LATE FILING PENALTY \$ _____
<input type="checkbox"/> EXTENSION/RENEWAL 20__	RECEIPT NO. _____	RECEIPT NO. _____
<input type="checkbox"/> AMENDMENT 20__	PAYMENT DATE _____	PAYMENT DATE _____

APPLICATION FOR INSURANCE LICENSE

(General Agent, Sub-Agent, Broker, Adjuster or Surplus Lines)

The undersigned hereby applies for a _____ license authorizing the transaction of the business of insurance in the Commonwealth of the Northern Mariana Islands, including the following classes of insurance:

- | | | | |
|---|---------------------------------|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Disability (Accident/Health) | <input type="checkbox"/> Life | <input type="checkbox"/> Property | <input type="checkbox"/> Vehicle |
| <input type="checkbox"/> General Casualty | <input type="checkbox"/> Marine | <input type="checkbox"/> Surety | |

Company Sponsor: _____
Name of Insurance Carrier

1. NAME OF APPLICANT: _____

2. BUSINESS MAILING ADDRESS: _____

3. BUSINESS PHYSICAL ADDRESS: _____

Tel No(s): _____ Fax No.: _____

Email: _____ Contact Person _____

4. APPLICANT'S FORM OF ORGANIZATION IS: (* provide copies of pertinent documents)
____ Proprietorship ____ Partnership ____ Corporation
____ Limited Liability Company ____ Other

5. Do you use any other name than the one stated in question No. 1, in the conduct of business?
_____ Yes _____ No

6. If the answer to question No. 5 is YES, give the name(s) of your business:

7. Is the license to be issued in the name of your business or in your personal name?
Please print the name as it would appear on the license.

8. If the applicant is a partnership or an association, give the name of all partners or members thereof; if a corporation, list the names and addresses of all officers of the corporation: (If more space is needed, attach a separate sheet.)

Name	Title	Address
Name	Title	Address
Name	Title	Address

9. If the applicant is a partnership, an association or a corporation, list the names of all individuals who are to be authorized to act under this license.

10. Is the person listed under item No. 9, a resident of the Commonwealth? _____ Yes _____ No

11. If the answer to item No. 10 is NO, give address of permanent resident of each:

12. Have you or any person listed under item No. 8 or No. 9, ever been denied or had an insurance license revoked? _____ Yes _____ No If, answer YES, a detailed letter of explanation must accompany this application.

13. Have you or any person listed under item No. 8 or No. 9, ever been convicted of a felony? _____ Yes _____ No If, answer is YES, a detailed letter of explanation must accompany this application.

14. Are you, and each person listed under item No. 8 or No. 9, familiar with the insurance laws of the Commonwealth and do you agree to conduct business in accordance therewith and do you understand that if you required to take an examination, there will be several questions on the laws that you must answer satisfactorily? _____ Yes _____ No

15. Is applicant, or any person listed under item No. 8 or No. 9, engaged in any other business, either full-time or part-time? _____ Yes _____ No If answer is YES, what is the nature of the other business?

16. Give any previous insurance business experience: _____
