



# Department of Commerce

COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS  
 P.O. Box 5795 CHR, 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 SOLICITOR'S LICENSE

The undersigned hereby applies for a Solicitor's License for 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   |                                  |

1. NAME OF APPLICANT: \_\_\_\_\_

2. BUSINESS MAILING ADDRESS: \_\_\_\_\_

3. BUSINESS PHYSICAL ADDRESS: \_\_\_\_\_

Tel No(s): \_\_\_\_\_ Fax No.: \_\_\_\_\_

Email: \_\_\_\_\_ Contact Person \_\_\_\_\_

APPLICANT'S FORM OF ORGANIZATION IS: (\* provide copies of pertinent documents)

\_\_\_\_\_ Proprietorship \_\_\_\_\_ Partnership \_\_\_\_\_ Corporation  
 \_\_\_\_\_ Limited Liability Company \_\_\_\_\_ Other

4. Are you a permanent resident of the Commonwealth? \_\_\_\_\_

5. Will your time be devoted exclusively to the insurance business? \_\_\_\_\_

6. If NO, what portion of your time will be devoted to insurance? \_\_\_\_\_

7. Give the following information with regard to your previous insurance experience, if any:

Date		Employer	Address of Employer	General Agent or Subagent	Class of Insurance
From	To				

8. Have you ever been denied or had an insurance license revoked? \_\_\_\_ YES \_\_\_\_ NO  
If answer is YES, a detailed letter or explanation must accompany application.
9. Have you ever been convicted of a felony? \_\_\_\_ YES \_\_\_\_ NO  
If answer is YES, a detailed letter of explanation must accompany application.
10. Are you familiar with the provisions of the contract(s) of insurance to be negotiated? \_\_\_\_  
\_\_\_\_\_
11. What instruction in insurance have you had? \_\_\_\_\_  
\_\_\_\_\_
12. What instruction in insurance do you expect to receive? \_\_\_\_\_  
\_\_\_\_\_
13. Are you familiar with the Insurance Laws of the Commonwealth and do you agree to your business in accordance therewith and do you understand that if you are required to take an examination, there will be several questions on the laws that you must answer satisfactorily? \_\_\_\_ YES \_\_\_\_ NO
14. The applicant hereby certifies that the principal use of the license applied for is not to effect insurance on the applicant's own life, property of risks, or the life, property or risks of employees or members of applicant's family.

**AFFIDAVIT**

Commonwealth of the Northern )  
 Mariana Islands ) SS:  
 Municipality of \_\_\_\_\_ )

The undersigned, being duly sworn, deposes and says that he/she is the person named in the foregoing application, that he/she knows the contents thereof, and that each of the statements made, and answers to the questions therein, are true of his/her own knowledge.

\_\_\_\_\_  
 (Signature of Applicant)

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_ .

\_\_\_\_\_  
 (Notary Public)

(SEAL)

My commission expires: \_\_\_\_\_