OFFICE OF THE
COMMISSIONER

STATE OF DELAWARE
DEPARTMENT OF INSURANCE

PHARMACY BENEFITS MANAGER NAME CHANGE APPLICATION

COMPLETED BY:

Printed Contact Name: Date:

Signature: Title:

Address:

Phone: E-Mail Address:

COMPANY INFORMATION:

Former Name:

New Name:

Home Office Address:

Mailing Address:

Phone:

FEIN:

REQUIREMENTS:

☐ 1. Attach copy of the name change approval from the company's state of domicile.

☐ 2. Surrender original PBM Certificate of Registration.

☐ 3. Attach amended or restated Articles of Incorporation or Organization certified by the domicile state.

☐ 4. Attach amended by-laws (if applicable) certified by the Secretary of the Company.

☐ 5. Designation of Person to receive Service of Process – Form D1.

Per Regulation 1411 – 8.0 Fees - $1,000 Amendment of Certificate.

Check must be made payable to **Delaware Department of Insurance** (only checks with the correct payee will be accepted).

Mail to: Company Regulation (BERG)
Delaware Department of Insurance
1351 West North Street, Suite 101
Dover, DE 19904

To ensure prompt processing of your application make sure all requirements have been met. Questions may be directed to DOIPBM@delaware.gov