TRINIDAD NAVARRO
COMMISSIONER

STATE OF DELAWARE
DEPARTMENT OF INSURANCE

VOLUNTARY SURRENDER
DELAWARE PHARMACY BENEFITS MANAGER CERTIFICATE

(PBM NAME) ______________________________ (PBM) is seeking to surrender and withdraw its authority to transact business in the State of Delaware and cancel its Delaware Pharmacy Benefits Manager (PBM) Certificate for the following reason(s):

Requested Effective Date: ____________________ DE PBM Certificate #: ________

Submitters Name and Email Address: ____

Applicant Officer's Certification and Attestation

The officer (listed below) of the Applicant must read the following very carefully:

Certification of Accuracy
I certify, under penalty of perjury, that I have reviewed this Voluntary Surrender filing in its entirety; that I am familiar with its contents; and that all information, statements, and attachments submitted are true, correct, and complete. I understand that providing false, misleading, or incomplete information may result in administrative action, certificate discipline, civil penalties, or criminal prosecution against me, the Applicant, or both.

Acknowledgement of Required Filings
I acknowledge that all reports, filings, and submissions required under Title 18 of the Delaware Code, including but not limited to Chapter 33A, and all applicable regulations, have been timely filed with the Delaware Department of Insurance.

Delaware Contracts
I confirm the PBM does not have any active contracts involving Delaware business.

Outstanding Obligations
I attest that the Applicant has no outstanding filings, corrective actions, data requests, or compliance obligations pending with the Delaware Department of Insurance. I understand that the PBM may still have reporting requirements for the prior years' business that they are still required to submit.

Compliance with Laws and Regulations

I acknowledge that I am familiar with the insurance laws, regulations and constitutional requirements of the State of Delaware as they relate to the Applicant's operations and to the withdrawal or surrender of its Pharmacy Benefits manager registration.

Authority to Execute

I affirm that I am the duly authorized President / Vice President / Secretary / Officer of the Applicant and that I am authorized to execute this Certification and Attestation on behalf of the Applicant.

Certification

I certify under penalty of perjury under the laws of the applicable jurisdiction that all statements made herein are true and correct. Executed at:
(City, State) ____

______________________________	_____________
Officer Signature	Date
______________________________	______________
Officer Full Legal Name	Officer Title
STATE OF: ____________________	COUNTY OF: _______

SUBSCRIBED AND SWORN to be this _____ day of ____________, __________.

Notary Public My Commission Expires _____________________

Please submit the completed form to DOIPBM@delaware.gov or to the Delaware Department of Insurance at the address listed below.