LOUISIANA DEPARTMENT OF INSURANCE

JAMES J. DONELON
COMMISSIONER

INSTRUCTIONS FOR EDUCATION PROVIDER APPROVAL

This packet is designed to assist the individual preparing this application in complying with our requirements and procedures. The forms and procedures of the application process are designed to facilitate our review of the application. Therefore, it is extremely important that all applicants comply fully with the instructions and requirements set forth in this packet.

Questions about the preparation of this application or prelicense education program requirements, may be directed to this Department at (225) 342-0860 or via email at producerlicensing@ldi.la.gov.

1) Initial applications for education programs must be submitted no less than thirty days prior to the first scheduled presentation of the program. Applications for new providers may be submitted simultaneously with course approvals. Provider renewals must be submitted no less than ninety days prior to the expiration of the certification of the program.

2) The Louisiana Department of Insurance (LDI) encourages electronic submission of the application via email. An application submitted in this manner must be submitted to producerlicensing@ldi.la.gov to assure receipt and prompt processing by this Department. After submission of the application electronically the payment of the fees must be submitted hard copy to the address above. The form entitled Payment Remittance for Electronic Submission must be completed and submitted along with all payments where the application is submitted electronically.

3) An application submitted electronically must include a completed and signed application form. The documents may be imaged using any of the standard image formats such as .pdf or .tif formats. An application submitted hard copy must include original signatures.

4) If the application is submitted hard copy, all submittals in association with this application must reach the LDI via the United States Postal Service or a carrier with interstate business. Hand delivery is not acceptable and any information arriving in this manner will be returned without review. All correspondence must be sent to the attention of the Education Review to assure prompt receipt and handling. Our mailing address is 1702 N. Third St. Baton Rouge, LA 70802.

5) Submit only a fully completed application. Submittal of a partially completed application will cause processing delays and may result in disapproval.

6) Do not alter the forms contained in this packet. If you feel the requirements do not apply to the applicant notify us. We will supply the proper form, if appropriate, and/or answer any questions you have about the forms.

7) All entries in the application forms must be typed or printed. Illegible entries or responses will be considered incomplete and may result in the disapproval of the application.

LOUISIANA DEPARTMENT OF INSURANCE

JAMES J. DONELON
COMMISSIONER

EDUCATION PROVIDER APPLICATION

SECTION 1- GENERAL INFORMATION

Demographic Information:

Provider Name:____

Provider FEIN Number:______________________

Business Address:____

Mailing Address:____

Phone:______________________________ Fax:______________________________

Website:____

Contact Person:____

Phone:______________________________ Fax:______________________________

Email Address of Contact:____

Application Type: *Check one.*

☐ New Provider ☐ Provider Renewal Provider number # ____________

Provider Program Type: *One or both may be selected.*

☐ Prelicense Education ☐ Continuing Education

Provider Entity Type: *Check one.*

☐ Insurance Trade Association ☐ Admitted Insurer

☐ Accredited College or University ☐ Other ______________________________

Attachments: *All of the following must be attached to this application.*

1. A general description of the types of programs presented by the provider.
2. A description of the qualifications and experience of the persons responsible for the creation of the program.

SECTION 2- SUPERVISORY INSTRUCTOR

Every provider must designate an individual as a supervisory instructor. This individual shall be responsible for assuring the quality of the program and for the conduct of any other instructors. You may attach a resume` or curriculum vitae which provides the requested information in lieu of completion of this portion of the form. The provider shall also maintain a signed statement from the supervisory instructor describing the basis for his/her qualification and an affirmation that he/she will comply with the regulatory requirements

Supervisory Instructor Identification Information: *Provide the requested information for the instructor. You must provide the full legal name of the instructor including the middle name.*

Instructor Name:____

Resident Address:____

Business Address:____

Current Occupation:____

Education and Training:

School or Training Facility Name	Dates Attended	Degree or Professional Designation Obtained

Membership in Professional Societies and Associations:

Name of Professional Society or Association	Dates of Membership

Professional Licenses:

License Type	*State/Jurisdiction*	*License #*	*Date Issued*

Other Qualifications: *Briefly describe any other qualifications, training, employment or skills which contribution to the ability of the instructor to teach the program and present the instructional material.*

SECTION 3 - MANAGEMENT AND OWNERS

Provide the names and addresses of every officer, director, partner or member or the provider as well as every person owning, directly or indirectly, 10 % or more of the provider. Additional names can be attached on a separate sheet

First Name	**Middle Name:**	**Last Name:**	
Address:			
Position:			**Ownership %::**
First Name	**Middle Name:**	**Last Name:**	
Address:			
Position:			**Ownership %::**
First Name	**Middle Name:**	**Last Name:**	
Address:			
Position:			**Ownership %::**
First Name	**Middle Name:**	**Last Name:**	
Address:			
Position:			**Ownership %::**
First Name	**Middle Name:**	**Last Name:**	
Address:			
Position:			**Ownership %::**
First Name	**Middle Name:**	**Last Name:**	
Address:			
Position:			**Ownership %::**
First Name	**Middle Name:**	**Last Name:**	
Address:			
Position:			**Ownership %::**

SECTION 4 - ATTESTATION

I, the undersigned, do hereby attest that all of the information contained in this application and all attachments hereto are true and correct. I do further attest that I am familiar with the requirements of the Louisiana Insurance Code and regulations relative to education requirements and confirm that the provider and program presented in this application are compliant with all provisions thereof.

______________________________ ______________________________

(Printed Provider Representative Name) (Signature of Provider Representative)

______________________________ ______________________________

(Title of Provider Representative) (Date)

LOUISIANA DEPARTMENT OF INSURANCE

JAMES J. DONELON
COMMISSIONER

PAYMENT REMITTANCE FOR ELECTRONIC SUBMISSION

This form is to be attached to a hard copy payment remittance made in association with the electronic filing of an education provider or program. This document MUST be attached to the payment for proper credit.

Provider Information: *Provide the requested information for the provider that submitted the program(s) for which payment is being remitted.*

Provider Name:____

Provider FEIN Number:__________________ Louisiana Provider Number*:____________________

Address:____

Contact Person:____

Phone:________________________________ Fax______________________________

Email Address of Contact:____

Amount of Payment Attached:______________ Check # __________________________

** The provider number must be supplied by providers who have previously had a program approved by the Louisiana Department of Insurance. If the provider is a first-time applicant, leave this blank.*

Submission Type

☐ Provider Approval or Renewal ($250) Date Submitted______________________________