MISSOURI DEPARTMENT OF COMMERCE AND INSURANCE

NOTIFICATION OF INSURER/TRUST AGREEMENTS

P.O. BOX 690
JEFFERSON CITY, MO 65102-0690
TPAFilings@insurance.mo.gov

INSTRUCTIONS

1. Please type. Additional copies of this form or an equivalent spreadsheet may be attached if more space is needed.
2. This form must be submitted with the annual report to the Department of Commerce and Insurance on or before March 1, as well as with new applications.
3. Please review section 376.1093, RSMo and 20 CSR 200-9.600 and 9.800 for more information on completing this form.

ADMINISTRATOR NAME

NAME OF INSURER/TRUST FOR WHICH THE ADMINISTRATOR HAD AN AGREEMENT DURING THE PRECEDING FISCAL YEAR.	LEGAL ADDRESS (STREET NUMBER AND NAME, CITY, STATE, ZIP CODE)	HOW IS INSURER OR TRUST INSURED: LICENSED CO., SELF-INSURER, OR STOP LOSS COVERAGE. PLEASE INDICATE BELOW.

On behalf of the Administrator, I verify the above insurer/trust agreement(s) exist with the Administrator.

AUTHORIZED SIGNATURE	TITLE	DATE