Hawaii Insurance Division
Continuing Education Program
Provider Approval Application

Provider Number *(Leave Blank)*:

PLEASE PRINT CLEARLY OR TYPE.
INCOMPLETE APPLICATIONS WILL BE REJECTED.
SUBMIT ORIGINAL SIGNED APPLICATION

Provider Name: CE Name:	FEIN Number:

Names and Titles of Owners or Officers (list below – use additional sheet if necessary):

Name / Title	*Street Address, City, State, ZIP Code, Phone Number*	*Designations and Licenses*

Physical Street Address (where records will be maintained): City State ZIP Code

Business Mailing Address (if different than physical address): City State ZIP Code

Business Voice Phone: ( ) (with Ext. #, if applicable)	Business Toll-Free Phone: ( ) (with Ext. #, if applicable)	Bus. Fax #: ( )

Business E-mail Address:	How long has this provider been in business?

Has this provider or any of its owners, officers, or provider directors, been convicted of a felony involving moral turpitude, or had an insurance, financial-services, or educational license suspended or revoked? If yes, please explain in detail on a separate sheet. [ ] Yes [ ] No

Has this provider or any of its owners, officers, or provider directors, been convicted of a misdemeanor violating any law regulating insurance, or a public offense having as one of its necessary elements a fraudulent act or an act of dishonesty in the acceptance, custody, or payment of money or property? If yes, please explain in detail on a separate sheet. [ ] Yes [ ] No

How will this provider record attendance, report credit hours, and maintain records?

Are you approved as a CE Provider in any other state(s)? [ ] Yes [ ] No If yes, which state(s)?	Are the courses open to the public? [ ] Yes [ ] No

Type of Organization (check one): [ ] Professional Organization [ ] Training Company [ ] Insurance Company [ ] College/University
[ ] Insurance Agency/Brokerage/ Wholesaler [ ] Other _____

Has this provider operated under any other name? [ ] Yes [ ] No
If yes, please provide the name and address of each business under which this provider has operated (*see* instructions for details, use separate sheet if needed).

Name	*Address*

Will this provider have an internet web site that lists the dates, times, and locations of courses approved for insurance continuing education credit?
[ ] Yes [ ] No If yes, please provide the web site address: _____

I certify that I have read the Hawaii Revised Statutes and agree to abide by those laws and the Hawaii insurance rules and regulations, the Americans with Disabilities Act, and all applicable state and federal equal employment opportunity and safety requirements. Additionally, I will require any instructors I utilize to teach courses to certify that they satisfy the requirements to be an instructor and to abide by those laws and rules applicable to instructors. I am aware that any failure to abide by the Hawaii Revised Statutes and rules may result in the termination of this provider's authorization to offer courses and that all course approvals will be simultaneously withdrawn.

_____ _____
Applicant's Signature Date

_____ _____
Print or Type Applicant's Name Title

OFFICE USE ONLY: *(Do Not write in this area)*

Effective Date: _____
Expiration Date: _____

I98 $_____
I51 $_____
I18 $_____

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THE FOLLOWING SECTION SHOULD BE COMPLETED BY THE PRIMARY CONTACT PERSON OF THE PROVIDER.
(List additional contact person(s), addresses, phone numbers, and e-mail on a separate sheet)

Contact Person of Provider: First Name	Middle Initial	Last Name	Jr./Sr., etc.

Physical Street Address of Contact Person:	City	State	ZIP Code

Business Mailing Address of Contact Person: (if different than physical address)	City	State	ZIP Code

Business Voice Phone: ( ) (with Ext. #, if applicable)	Business Toll-Free Phone: ( ) (with Ext. #, if applicable)	Bus. Fax #: ( )

E-mail Address:

_____ _____
Contact Person Signature Date

_____ _____
Print or Type Name of Contact Person Title

It is imperative that providers notify the Hawaii Insurance Division in writing to update any changes to information submitted on this application.