LOUISIANA DEPARTMENT OF INSURANCE

TIMOTHY J. TEMPLE
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.

Direct all communication to:

Louisiana Department of Insurance Producer Licensing PO Box 94214 Baton Rouge, LA 70804-9214	Physical Address: 1702 N. 3rd St. Baton Rouge, LA 70802	Phone: (225) 342-0860 Fax: (225) 342-3754 E-Mail: cefiling@ldi.la.gov

Education providers must be approved prior to submitting course approval applications. Instruction will be supplied to the provider regarding the online course submission process. Provider approvals are valid for 3 years from the date of approval. Provider renewals must be submitted no less than ninety days prior to expiration. Expiration of a provider approval will result in the inactivation of all course approvals for that provider.

The Louisiana Department of Insurance (LDI) encourages electronic submission of the application via email to cefilings@ldi.la.gov to assure prompt processing by this Department. If submitting electronically, fee payment must be mailed to the address above. Include a completed Payment Remittance for Electronic Submission with the payment submission.

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.

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.

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

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

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.

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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 Entity Type: *Check one.*

☐ Insurance Trade Association ☐ Admitted Insurer

☐ Accredited College or University ☐ Other _____

Fees:

Initial or Renewal Provider Approval $ $250.00

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 qualifications 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:_____

Business Phone Number:_____ Email 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 contribute 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)

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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: _____

Date Application was submitted: _____

** 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.*