# Registration Form

**Submitting Entity Information**

Full Company Name _____

Mailing Address _____

City _____ State _____ Zip Code _____

State of Domicile _____ Date Commenced Business in Hawai'i _____

NAIC Code (if applicable) _____ Approximate Number of Covered Lives _____

**Type of Business**

☐ Health Plan ☐ Third-Party Administrator ☐ Pharmacy Benefit Manager

☐ Dental Health Plan ☐ Government Agency ☐ Other, please describe _____

**Primary Point of Contact Information**

First Name _____ Last Name _____

Company Name _____

Title _____ Email Address _____

Phone _____ Fax _____

Mailing Address _____

City _____ State _____ Zip Code _____

**Secondary Point of Contact Information**

First Name _____ Last Name _____

Company Name _____

Title _____ Email Address _____

Phone _____ Fax _____

Mailing Address _____

City _____ State _____ Zip Code _____

**Person Completing Registration Form**

Signature _____

First Name _____ Last Name _____

Title _____