Form TPA Rev. 9/01/2019	ARKANSAS WORKERS' COMPENSATION COMMISSION TPA ADMINISTRATION 324 S. Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	TPA
Ark. Code Ann. 11-9-302 (b) and AWCC Rule 099.38		

THIRD PARTY ADMINISTRATOR
Application / Registration Form

Date_____

1. Applicant (legal) Name: _____
2. Federal Employer Identification Number (FEIN): _____
3. Applicant Trade Name / DBA Name: _____
4. Applicant Home Office Address: _____
5. Applicant Main Phone _____ Applicant Toll Free _____
6. Applicant is: ☐ Corporation, ☐ Partnership, ☐ Individual, ☐ Other (specify) _____
7. Indicate the desired effective date for Third Party Administrator approval: _____

   Complete items 8 through 11 for the person who will serve as the company's Administrator (home office contact) to the Commission regarding renewing the TPA authority and compliance with Commission Rules.

8. Administrator's Name: _____
9. Administrator's E-mail Address: _____
10. Administrator's Mailing Address: _____
11. Administrator's Direct Phone _____ Fax _____ Toll Free _____
12. Complete the following for each location that will be handling Arkansas workers' compensation claims. If the Administrator (above) will also be a claims location contact, please repeat the above information in the blanks below. Please complete the same information for each additional location handling Arkansas claims. If there are more than four (4) locations at which claims will be handled, please copy page 2 and include the additional page(s) with the application.

    Location Name: _____

    Location Physical Address: _____

    Location Mailing Address: _____

    Claim Manager: _____

    Claim Manager Direct Phone _____ Fax _____ Toll Free _____

    Claim Manager E-mail Address _____

    Office Generic E-mail Address _____

    All adjusters handling claims as a TPA must be licensed and have the WC Line of Authority. In order to qualify an office, please provide the name (as it appears on the license) and the Arkansas adjuster license (NPN) number for one adjuster physically located in the claim office.

    Qualifying Adjuster Name _____ License Number _____

Location Name: ____

Location Physical Address: ____

Location Mailing Address: ____

Claim Manager: ____

Claim Manager Direct Phone ____________________ Fax ____________________ Toll Free ____________________

Claim Manager E-mail Address____

Office Generic E-mail Address____

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Qualifying Adjuster Name ____ License Number ________________

Location Name: ____

Location Physical Address: ____

Location Mailing Address: ____

Claim Manager: ____

Claim Manager Direct Phone ____________________ Fax ____________________ Toll Free ____________________

Claim Manager E-mail Address____

Office Generic E-mail Address____

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Qualifying Adjuster Name ____ License Number ________________

Location Name: ____

Location Physical Address: ____

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Claim Manager: ____

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Qualifying Adjuster Name ____ License Number ________________

This application is to be completed and sent with the application fee of one hundred dollars ($100) payable to the **Arkansas Workers' Compensation Commission,** P. O. Box 950, Little Rock, AR 72203-0950.

I certify that the information submitted with this application is true and correct to the best of my knowledge. Further, I agree to update any change in locations, location personnel or report any data material to this application to the Commission as the need may arise.

_____
Legal Name of Applicant

_____
Name(Print) of Authorized Official of Applicant

_____
Title of Official

_____
Signature of Official

_____
Date

State of _____

County of _____

Subscribed and sworn to before me by _____ _____

on this _____ day of _____, 2 _____.

(Seal)

_____
Notary Public

My commission expires: _____.