LOUISIANA DEPARTMENT OF INSURANCE

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

Education providers must be approved prior to submitting course approval applications. The Louisiana Department of Insurance (LDI) will provide instruction to the education provider regarding the application process for the provider's courses after the provider is approved. Being approved as a provider does not automatically approve any courses offered by a provider and a provider may not offer any course for continuing education credit before approval for that course is obtained. Provider approvals are valid for three years from the date of approval. Provider renewals must be submitted no less than 90 days prior to expiration. Expiration of a provider approval will result in the inactivation of all course approvals for that provider.

All entities regulated by Louisiana Department of Insurance (LDI) are required to provide and maintain accurate contact information in order to receive and respond to Department communications and inquiries. As part of this application, the provider must identify a person as their education provider contact. Providers must report changes to the education provider contact person identified in this application within 30 days.

LDI encourages electronic submission of the application via email cefilings@ldi.la.gov to assure prompt processing by this department. LDI prefers the application to be in PDF format. Documents in file types that cannot be opened or contain security features such as passwords that inhibit our ability to review and process the application will be returned unprocessed. If submitting electronically, use a completed Payment Remittance for Electronic Submission form when mailing in the application fee. Please note that LDI will not begin reviewing the application until the Licensing Division receives both the application and the fee.

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.

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 to the you, contact 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.

EDUCATION PROVIDER APPROVAL APPLICATION

SECTION 1- GENERAL INFORMATION

Demographic Information:

Provider Name: ____

Provider FEIN Number: ______________________

Business Address: ____

Mailing Address: ____

Phone: ______________________ Fax: ______________________

Website: ____

Education Provider Contact: *LDI staff will direct any questions regarding this application and all future communications with the individual identified as the education provider contact. Providers must report any changes to the contact information to LDI within 30 days.*

Name: ____

Title: ______________________ Direct Phone: ______________________

Contact Email Address of Contact: ______________________________________

Application Type: *Check one.*

☐ New Provider ☐ Provider Renewal Provider number # ___________

Fees:

Initial or Renewal Provider Approval Fee	$ $250.00

SECTION 1- GENERAL INFORMATION (continued)

Provider Entity Type: *Check one.*

☐ Insurance Trade Association

☐ Admitted Insurer

☐ Accredited College or University

☐ Other ___________________________________

Please provide a general description of the types of programs to be presented by the provider. You may include a separate attachment if you need additional space.

Please provide a description of the qualification and experience of the persons responsible for the creation of the program. You may include a separate attachment if you need additional space.

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: ____

Resident 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. Attach additional names 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)

LOUISIANA DEPARTMENT OF INSURANCE

PAYMENT REMITTANCE FOR ELECTRONIC SUBMISSION

Use this form for a hard copy payment remittance made in association with the electronic filing of an education provider or program. Attach this document 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:_________________________
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.