

Form TPA Rev. 8/01/2006	ARKANSAS WORKERS' COMPENSATION COMMISSION TPA ADMINISTRATION 324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-2783 / 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 Rule 099.38.

8. Administrator's name: _____
9. Administrator's E-mail address: _____
10. Administrator's mailing address: _____
11. Administrator's direct phone #: _____ Fax #: _____

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 five (5) locations at which claims will be handled, please copy page 2 and include the additional page(s) with the application.

Location Name: _____

Claim Manager: _____

Claim Manager E-mail address _____

Claim Manager Direct Phone _____ Claim Manager Fax _____

Location Mailing Address: _____

Location City: _____ Location State: _____ Location Zip: _____

Location Name: _____

Claim Manager: _____

Claim Manager E-mail address _____

Claim Manager Direct Phone _____ Claim Manager Fax _____

Location Mailing Address: _____

Location City: _____ Location State: _____ Location Zip: _____

Location Name: _____

Claim Manager: _____

Claim Manager E-mail address _____

Claim Manager Direct Phone _____ Claim Manager Fax _____

Location Mailing Address: _____

Location City: _____ Location State: _____ Location Zip: _____

Location Name: _____

Claim Manager: _____

Claim Manager E-mail address _____

Claim Manager Direct Phone _____ Claim Manager Fax _____

Location Mailing Address: _____

Location City: _____ Location State: _____ Location Zip: _____

Location Name: _____

Claim Manager: _____

Claim Manager E-mail address _____

Claim Manager Direct Phone _____ Claim Manager Fax _____

Location Mailing Address: _____

Location City: _____ Location State: _____ Location Zip: _____

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: _____.