



Minnesota Department of Commerce

85 7th Place East, Suite 280
Saint Paul, MN 55101
PHONE: 651-539-1599

DOC OFFICE USE ONLY

APPROVED DENIED RETURNED

By _____ Date _____

Insurance Use Only

STANDARD EDUCATION PROVIDER APPLICATION
Coordinator Approval

PROVIDER NUMBER

DATE PROCESSED

Application FEE \$100

Primary Coordinator

- Is this application submitted to replace a current Coordinator for this Provider?
Provide the terminated Coordinator name:
Date prior Coordinator terminated:

PROVIDER INFORMATION

Provider / School Name *

Assumed Name (If different than line above.)

Provider Physical Location - Street Address:

City State Zip

Mailing Address (If different than above>)

City State Zip

FEIN Business Phone Ext Toll Free Number

Business Fax

Corporations, LLCs, LPs, LLPs, and any other Business Entities:

Business E-mail Address Business Web Site Address

Check One:

- Individual Proprietorship Corporation Limited Liability Company/Corporation (LLC) Partnership
Limited Partnership (LP) Limited Liability Partnership (LLP) Other Business Entity

Note: Non-Profit business entities must check corresponding box above.

Is this a Foreign Business Entity (organized in another state)? No Yes; list state (See #3 below.)

Attach the following supporting business entity documentation:

- 1. Completed "Disclosure of Owners, Partners, Officers" form located at end of application.
2. Completed "BCA" form for Coordinator and every individual listed on "Disclosure form.
3. Copy of filed MN Certificate of Authority to transact business in MN if application is for a business entity not organized and filed in MN with the MN Secretary of State (example: a non-resident / foreign corporation).
4. Copy of the most recently filed business entity W-9 form.
5. Copy of the most current non-profit filing (if non-profit).
6. Copy of business entity organization documents filed and stamped as required by MN Secretary of State.
7. Copy of Partnership Agreement signed and dated by all partners and MN filed copy of Certificate of Assumed Name Worksheet.

*Note: If Provider will be doing business in Minnesota under any name other than the exact legal individual name or exact legal business entity name filed with the MN Secretary of State (and entered on line one above) also attach a copy of the Certificate of Assumed Name Worksheet, filed and stamped by the MN Secretary of State. The Certificate of Assumed Name Worksheet must show that the name entered on line one above owns the name listed as the Assumed Name entered on line two above.

Make sure that you are submitting the most current revision of this application located at http://mn.gov/commerce/. Outdated submissions will be returned without review.

COORDINATOR INFORMATION ----- All Requested Information is Required.

FULL LEGAL NAME

Last Name _____, First Name _____, Middle _____

Social Security Number _____, DOB _____

Coordinator Daytime Business Address: _____,

City _____, State _____, Zip _____.

Coordinator **Direct** Business E-mail Address _____

Coordinator **Direct** Business Phone _____ Ext _____ Toll Free Number _____

A Coordinator must meet one of the three qualifications listed below.

Check at least one qualification; complete the requested information; and attach required documentation.

5 years experience within the previous six years, in the regulated industry for which Provider offers license education courses (Attach Copy of Insurance License (if hold/held current/past), Resume and/or Bio, and a signed and dated experience verification letter from Supervisor.)
Name and Location of Entity where applicant obtained Insurance industry experience

(City/State) _____.
Dates Employed from (mo/yr) _____ to (mo/yr) _____

Degree in Education plus 2 years experience during the immediately preceding five-year period in the regulated industry for which Provider offers license education courses (Attach Copy of Transcript)
Name and Location of Educational Institution where applicant obtained degree

(City/State) _____.
Name of Degree _____ Major _____
Dates of Attendance from (mo/yr) _____ to (mo/yr) _____
(Attach Copy of Insurance License (if hold/held current/past), Resume and/or Bio, and a signed and dated experience verification letter from Supervisor.)
Name and Location of Entity where applicant obtained Insurance industry experience

(City/State) _____.
Dates Employed from (mo/yr) _____ to (mo/yr) _____

3 years full-time experience administering an education program (experience must be within 5 years immediately prior to application) (Attach Copy of Insurance License (if hold/held current/past), Resume and/or Bio, and a signed and dated experience verification letter from Supervisor.)
Name and Location of Educational Institution where applicant was administrator

(City/State) _____.
Describe Educational Program _____ Title _____
Dates Employed from (mo/yr) _____ to (mo/yr) _____

All Licensing Education, Provider and Coordinator applicants must answer the following questions.

Note: The definition of applicant includes ALL of the following: Individual coordinator; Provider owners, individual proprietors, partners, officers, directors, governors, managing members, and/or any shareholders owning 10% or more of the stock.

Please answer YES if the Applicant has ever:

1. Been affiliated with any License Education Provider as an owner, officer, manager, solicitor, or coordinator that has been approved, licensed, or registered in any state including Minnesota? Attach explanation if, Yes.	YES <input type="checkbox"/>	NO <input type="checkbox"/>
2. Had any occupational, professional or vocational license or permit censured, suspended, revoked, canceled, terminated, or been the subject of any type of administrative action in any state including Minnesota? If yes, you must attach: a) a written statement, signed and dated by applicant, explaining the circumstances of each incident, b) a copy of the Notice of Hearing or other document that states the charges and allegations, and c) a copy of the official document which establishes the resolution of the charges or any final judgment.	YES <input type="checkbox"/>	NO <input type="checkbox"/>
3. Been owner, principal, officer, partner or owned stock in any company that has failed in business, made a compromise with creditors, or filed a bankruptcy petition or been declared bankrupt? If yes, attach written explanation signed and dated by applicant (including specific dates), list the company name(s), and attach copy of the company's bankruptcy disposition; this includes personal bankruptcies for individual proprietors.	YES <input type="checkbox"/>	NO <input type="checkbox"/>
4. Been charged, indicted, pleaded to, or convicted of any criminal offense in any Court? Include felonies, gross misdemeanors or misdemeanors. Do not include traffic violations less than felony. If yes, you must attach: a) a written statement, signed and dated by applicant, explaining the circumstances of each incident, b) a copy of the charging document, c) a copy of the official document which establishes the resolution of the charges or any final judgment, and d) if currently on probation, attach letter from probation officer stating your compliance with terms of probation.	YES <input type="checkbox"/>	NO <input type="checkbox"/>
5. Is/was, this provider, currently/previously, ever licensed in Insurance in any state including MN? If yes, submit the license type, license number, FEIN, state, and attach verifiable documentation <u>for each</u> . (Provider business only; unless coordinator is an IP provider.)	YES <input type="checkbox"/>	NO <input type="checkbox"/>
6. Is this provider currently one of the following in MN? <input type="checkbox"/> bona fide Insurance trade assoc, <input type="checkbox"/> degree-granting institution, <input type="checkbox"/> private school: If yes, submit details and documentation. (Provider business only; unless coordinator is an IP provider.)	YES <input type="checkbox"/>	NO <input type="checkbox"/>

PROVIDER APPLICANT CERTIFICATION & SIGNATURE

I hereby certify that all of the information submitted in this application and attachments is true and complete, and that this document has not been altered in any manner from the form adopted by the Department of Commerce. **I further certify that the individual listed on this application as the individual coordinator has our complete authority and permission to act as the Minnesota education coordinator for our business entity.**

**CORPORATION / LLC
SIGNATURE OF OFFICER**

**PARTNERSHIP / LP / LLP
SIGNATURE OF PARTNER**

**INDIVIDUAL PROPRIETOR
SIGNATURE of owner INDIVIDUAL**

Authorized Officer's Signature (Mandatory)
Printed Name and Title
Date Signed

General Partner's Signature (Mandatory)
Printed Name
Date Signed

Individual's Signature (Mandatory)
Printed Name
Date Signed

COORDINATOR APPLICANT CERTIFICATION & SIGNATURE

- I understand that a Coordinator is responsible for supervising the Provider's license education program and assuring compliance with Minnesota education laws, including signing course completion certificates if used, maintaining student attendance records, being available to instructors and students throughout course offerings, supervision of course instructors, ensuring coverage of all points in the course outline approved by the Commerce Department, ensuring adequacy of classroom facilities, and investigating complaints.
- I understand that a Coordinator is responsible for notifying the Commerce Department within 10 days of any change in applications for approval on file with the Commerce Department, and for notifying the Commerce Department within 10 days of any felony or gross misdemeanor conviction, or of disciplinary action taken against any occupational license held by, the Provider, Coordinator or an instructor teaching an approved offering.
- I certify that all of the information submitted in this application and attachments is true and complete, and that this document has not been altered in any manner from the form adopted by the Commerce Department.

Signature of Coordinator Applicant (Mandatory)

Date

DISCLOSURE FORM OWNERS, PARTNERS, OFFICERS For Minnesota License Education Providers

License Education Provider Business Entity Name:

FEIN#

(Print or Type)

Business Structure:	Instructions:
<input type="checkbox"/> Individual Proprietor	Provide name and address of the Owner. If industry licensed (present or past) as an individual, provide license details.
<input type="checkbox"/> Partnership <input type="checkbox"/> General Partnership <input type="checkbox"/> Limited Partnership <input type="checkbox"/> Limited Liability Partnership	Provide name and address of all Partners and their percent of Ownership. If industry licensed (present or past) as an individual or business entity, provide license information for each partner.
<input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company	<u>Provide name and address of all Officers, Owners, and Members regardless of the % of ownership;</u> plus any Shareholders owning 10% or more of the stock. If any Officer/Owner/Member/Shareholder holds (held) an industry license as an individual or business, provide license information.
<input type="checkbox"/> Non-Profit - Must also check corresponding business structure box above	Note: Non-Profit business entities must also list below all individuals required in the instructions above for their corresponding business structure.

If any listing below is another business entity you must attach a Disclosure form for "each" subsequent business entity.

Attach additional sheets if necessary to disclose all owners, individual proprietors, partners, officers, members, and any individual industry license information.

Name		Prof License Type		License #
Business / Daytime Address		City/State/Zip	Issuing State	Date Issued Date Term'd
Title & Ownership <i>(check all that apply)</i>	<input type="checkbox"/> Indiv Prop <input type="checkbox"/> Corporate Officer (% of Ownership ____% Title: _____)		<input type="checkbox"/> Shareholder (% of Ownership: ____%)	
	<input type="checkbox"/> LLC Owner / Member (% of Ownership ____% Title: _____)		<input type="checkbox"/> General Partner <input type="checkbox"/> Limited Partner (% of Ownership ____%)	
Name		Prof License Type		License #
Business / Daytime Address		City/State/Zip	Issuing State	Date Issued Date Term'd
Title & Ownership <i>(check all that apply)</i>	<input type="checkbox"/> Indiv Prop <input type="checkbox"/> Corporate Officer (% of Ownership ____% Title: _____)		<input type="checkbox"/> Shareholder (% of Ownership: ____%)	
	<input type="checkbox"/> LLC Owner / Member (% of Ownership ____% Title: _____)		<input type="checkbox"/> General Partner <input type="checkbox"/> Limited Partner (% of Ownership ____%)	
Name		Prof License Type		License #
Business / Daytime Address		City/State/Zip	Issuing State	Date Issued Date Term'd
Title & Ownership <i>(check all that apply)</i>	<input type="checkbox"/> Indiv Prop <input type="checkbox"/> Corporate Officer (% of Ownership ____% Title: _____)		<input type="checkbox"/> Shareholder (% of Ownership: ____%)	
	<input type="checkbox"/> LLC Owner / Member (% of Ownership ____% Title: _____)		<input type="checkbox"/> General Partner <input type="checkbox"/> Limited Partner (% of Ownership ____%)	
Name		Prof License Type		License #
Business / Daytime Address		City/State/Zip	Issuing State	Date Issued Date Term'd
Title & Ownership <i>(check all that apply)</i>	<input type="checkbox"/> Indiv Prop <input type="checkbox"/> Corporate Officer (% of Ownership ____% Title: _____)		<input type="checkbox"/> Shareholder (% of Ownership: ____%)	
	<input type="checkbox"/> LLC Owner / Member (% of Ownership ____% Title: _____)		<input type="checkbox"/> General Partner <input type="checkbox"/> Limited Partner (% of Ownership ____%)	

CERTIFICATION: I certify that all of the information above is true and complete, and that this document has not been changed in any manner from the form adopted by the Department of Commerce.

Printed Name	Signature	Title	Date
<i>Signer Must be Owner/Partner/Officer/Member of above Business Entity</i>			

If any listing above is another business entity you must attach a Disclosure form for "each" subsequent business entity.



MINNESOTA DEPARTMENT OF
COMMERCE

Minnesota Department of Commerce
85 7th Place East, Suite 500, Saint Paul, MN 55101

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BCA FORM

**Bureau of Criminal Apprehension
Criminal Background Check**

THIS BCA FORM MUST BE COMPLETED AND SIGNED BY ALL APPLICANTS

Note: The definition of applicant in this case includes **ALL** of the following: individual education coordinators; all officials for the education provider business entity, including but not limited to, individuals, officers, partners, directors, governors, managing members, owners, and shareholders owning 10% or more of the stock.

Note: The definition of business entity in this case includes but is not limited to, Individual Proprietors, Corporations, Limited Liability Companies/Corporations (LLCs), Partnerships, Limited Partnerships (LPs), and Limited Liability Partnerships (LLPs), Non-Profits.

THE DEPARTMENT OF COMMERCE REQUIRES THIS INFORMATION TO CONDUCT CRIMINAL HISTORY CHECKS.

TO: Bureau of Criminal Apprehension

(Only one individual per BCA form)

RE: Request for Criminal Background Check

PROVIDE PERSON'S COMPLETE LEGAL NAME	Please Print or Type
LAST NAME (if legal last name is hyphenated, enter both names here)	

FIRST NAME	MIDDLE NAME
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ADDITIONAL MIDDLE NAME (if applicable)	MAIDEN NAME (if applicable)	FORMER LAST NAME or OTHER NAME (if applicable)
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DATE OF BIRTH (mo/day/yr)	SOCIAL SECURITY NUMBER
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TYPE OF APPROVAL FOR WHICH YOU ARE APPLYING
MN PROFESSIONAL LICENSE EDUCATION PROVIDER and/or COORDINATOR APPROVAL
NAME OF THE COMPANY _____
COMPANY'S ASSUMED NAME (if applicable) _____
COMPANY'S STATE TAX IDENTIFICATION NUMBER _____
YOUR TITLE OR POSITION IN THE COMPANY _____

CERTIFICATION AND AUTHORIZATION:

- **I, the undersigned, and/or my company, have made application to the Minnesota Department of Commerce for approval as a regulated professional license education provider/coordinator.**
- **I certify that complete and accurate responses have been provided for all questions on the application.**
- **I hereby request and authorize the Bureau of Criminal apprehension to conduct a background check of me through their records for regulated professional license education provider/coordinator approval purposes.**

Signature (mandatory)

Date