***(Company Name)***

**Certification of Compliance**

**Florida Office of Insurance Regulation**

**Reporting for the Year\_\_\_\_\_\_**

I,  *(Name of Company Office) ,* do hereby certify that I am currently the  *(Title)*  of  *(Company Name)* and as such do hereby certify that the Company’s pharmacy benefits plan(s) or program(s) are in compliance with the requirements of section 626.8825, Florida Statutes.

Signature of Company Officer Date

Title

*­­­*

STATE OF \_\_\_\_\_\_\_\_\_\_\_\_\_\_

COUNTY OF \_\_\_\_\_\_\_\_\_\_\_\_

Sworn to and subscribed before me by means of ☐ physical presence or

☐ online notarization, this \_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_ 20\_\_, by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (name of person)

 as\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 (type of authority; e.g., officer, trustee, attorney in fact) (company name)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Signature of the Notary)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Print, Type or Stamp Commissioned Name of Notary)

Personally Known \_\_\_\_\_\_OR Produced Identification

Type of Identification Produced

My Commission Expires \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_