



REQUEST FOR WAIVER

I request a waiver of the FY 2022 Prescription Drug Affordability Fund Assessment because the assessment exceeds 1% of my organization's Maryland revenue in FY ____.

In support of this request I state:

- I, _____ (name) am over 18 years of age and am competent to make this request.
- I am the/a _____ (position title) for the assessed entity and the following information is true and correct:

Assessed Entity Name: _____

Contact E-mail: _____

Contact Phone: _____

Address: _____

Invoice Number: _____

Permit/NAIC Number(s): _____

FEIN Number: _____

- The FY 2022 Prescription Drug Affordability Fund Assessment exceeds 1% of my organization's Maryland revenue in FY ____ (year).
- I have attached the following documentation in support of my statement concerning the assessed entity's revenue and in support of this request (please check):

_____ First page of entity's Maryland taxes for year ____ (redacted)

_____ Other Documentation (Please describe): _____

I solemnly affirm under penalty of perjury that the contents of this document are true and accurate to the best of my knowledge, information and belief.

Signature

Date

Printed Name