



REQUEST FOR EXEMPTION

I request an exemption from the FY 2022 Prescription Drug Affordability Fund Assessment. In support of this request I state:

- 1) I, _____ (name) am over 18 years of age and am competent to make this request.
- 2) 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): _____
- 3) I request an exemption from the assessment because (please check all applicable):
 - a) _____ The assessed entity is not a qualifying entity as defined in COMAR 14.01.01 and Health Gen. § 21-2C-11(b)(1). Explanation of why entity is not a qualifying entity:
 - b) _____ The assessed entity no longer does business in Maryland. Explanation of Maryland status (e.g., expired registration/permit, etc.):
 - c) _____ Other reason for exemption request. Please explain:

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