State of California Department of Insurance

Prelicensing/Continuing Education Program Out-of-State Provider Jurisdiction Agreement

LIC 446-40 (Rev 01/21)

Curriculum and Officer Review Bureau- Education Unit
320 Capitol Mall
Sacramento, CA 95814-4309
(916) 492-3064
www.Insurance.ca.gov

Instructions:	**Department Use Only:**
* This form must be completed by every provider and provider applicant whose head office is located outside of California.	Provider Number _____ Date Received _____

Provider Number (if none, mark "pending"): _____ Date: _____

Provider Name: _____ Telephone: (____)_____

Address: _____
Street City State Zip

On behalf of the above named provider, I stipulate and agree:

(a) That in any action or special proceeding brought against the provider in the State of California, any document or process may be served on the Commissioner with the same effect as though served upon the provider, and such service will give jurisdiction over the provider to the same extent as if the provider were a resident of the State of California.

(b) That any action or special proceeding brought by the provider against the Insurance Commissioner of the State of California shall be brought in the County of Los Angeles, County of Sacramento or the City and County of San Francisco.

(c) That the provider will appear at the Office of the Insurance Commissioner in the County of Los Angeles, County of Sacramento or City or County of San Francisco at any time, pursuant to notice of hearing, order to show cause, or subpoena issued by the Commissioner, if such document is deposited in the United States mail, certified and postage prepaid, in a cover addressed to the provider at the last address filed by it with the Commissioner, such deposit in mail being 31 or more days before the date specified in such document for such appearance, and that in the event of failure so to appear the provider hereby consents to rescission or denial of provider certification by the Commissioner.

Provider Director Name: _____
(Print or type)

Provider Director Signature: _____ Date: _____