1. Name of Company: _______________________________________________________

2. Name of Network submitted: ______________________________________________

3. Type of Network: ___________HMO ___________POS ___________PPO

4. Indicate every Kentucky county within your approved service area for this network:
   _______________________________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________

5. Are you currently marketing this network? ___________Yes ___________No

6. Is this network used on the exchange? ___________Yes ___________No

7. Under what name (s) do you market this network? ________________________________
   _______________________________________________________________________

8. Currently Marketed to (place check mark before each appropriate item):
   _______ Individual Market      _______ Small Group
   _______ Large Groups          _______ Individual Associations
   _______ Group Associations    _______ Employer Organized Association Group

9. Indicate every Kentucky county in which you are currently marketing this network (This may not include every county within your approved service area): __________________
   _______________________________________________________________________

10. Name, phone number and e-mail address of Individual to contact if problems are encountered with submitted files:
   ____________________________  ____________________________  __________________
   (Please Print Name)           (Phone Number)            (E-Mail Address)

11. ____________________________
    (Signature of individual completing this form)

For EACH network you must submit:
(1)  One Access Data Base file;
(2)  A current provider directory for the network; and
(3)  This form completed in its entirety.