Service Area Expansion

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. Indicate every Kentucky county you wish to expand into:
   ___________________________________________________________________________
   ___________________________________________________________________________
   ___________________________________________________________________________

6. Will this network be used on the exchange? __________ Yes __________ No

7. Under what name (s) do you intend to market this network?
   ___________________________________________________________________________

8. Intended market type(s) (place check mark before each appropriate item):
   _____ Individual Market        _____ Small Group
   _____ Large Groups            _____ Individual Associations
   _____ Group Associations      _____ Employer Organized Association Group

9. Name and phone number of individual to contact if problems are encountered with submitted files:
   ____________________________________   ____________________________   ____________
   (Please Print Name)                  (E-Mail Address)                  (Phone Number)

10. ________________________________________________________________
    (Signature of individual completing this form)

For EACH network expansion you must submit:
   (1) One Provider Access database file;
   (2) This form completed in its entirety.