Kentucky Department of Insurance
Division of Health Insurance Policy and Managed Care

GUARANTEED ACCEPTANCE PROGRAM (GAP) DATA CERTIFICATION FORM

I, ____, certify that the information contained in this report for

____, _______________ is valid and accurate.
(Company Name) *(NAIC#)*

Reporting Period: *(Check one)* **Monthly: ______** **Annual: ______**

For Monthly GAP reports, state the: ____________________ ______________
(Month) **(Year)**

For Annual GAP reports, state the: _____________________
(Calendar Year)

________________________________ ________________________
(Signature) **(Date)**