Department of Insurance
Division of Health and Life

ADDITIONAL HEALTH INFORMATION REQUEST FORM

«Current Date»

«Company_Name»
Attn: «Contact_Person»
«Address1» «Address2»
«City» «State» «Zip»

RE: Co. Ltr Date: «Co_Letter_Date» Fax No: «Fax_No»
Form No: «Form_No»
Co. Filing No.
Date Received: «Date_Received» KY DOI Filing No: «KYDOI_File»

The information referenced above cannot be accepted as submitted because of the following reason(s) and/or omissions:

( ) HIPMC-F1 Face Sheet & Verification form was not submitted.
( ) Filing fee in accordance with 806 KAR 4:010 or the domiciliary state fee, whichever is greater.
( ) Filing fee of $50.00 for risk sharing agreement pursuant to 806 KAR 17:300, Section 2(3)(b)2.
( ) Filing fee of $25.00 for provider agreement ( ) or subcontract agreement ( ) pursuant to 806 KAR 17:300, Section 2(3) (b)1.
( ) HIPMC-F11 form was not submitted.
( ) A Statement of Variability was not submitted.
( ) Duplicate form numbers were submitted.
( ) Revised form letter of explanation was not submitted.
( ) Flesch score (Reference 806 KAR 14:121)
( ) Actuarial Certification (Form HIPMC-R4)
( ) Actuarial Memorandum ( ) Rates ( ) Signature on
( ) HIPMC-R36 Rate Filing Information Form
( ) Other

If the requested item(s) are not received within **thirty (30)** days from the date of this letter, the forms involved **will not** be retained for future reference.