COMMONWEALTH OF KENTUCKY
DEPARTMENT OF INSURANCE

HEALTH POLICY FORMS FILING
CERTIFICATION PRIVILEGE PROGRAM

Company Name:_____NAIC No.: _____

Form Number(s) and Title of Form(s):_____

I have reviewed or supervised the preparation of the above form(s) and certify that the form(s) comply with all of the applicable requirements of the Kentucky Revised Statutes and regulations. I also acknowledge responsibility for the validity, accuracy and completeness of the contents of the letter of transmittal and enclosures with this filing.

I understand that the Commissioner of Insurance may at any time review the form(s) submitted under the Certification Privilege Program and disapprove any form(s) not in compliance with the statutes and regulations. Further, any form found not to be in compliance with insurance statutes and regulations, shall cause the company to be subject to penalty(ies) as provided by statute and loss of the certification privilege.

_____ _____

Date Signature of President or designated representative

_____

(Type name of person signing above)

_____

(Type title of person signing above)

HIPMC-F2 (07/2008)