KY DEPARTMENT OF INSURANCE
LIMITED HEALTH SERVICE BENEFIT PLAN SUMMARY SHEET – FORM FILINGS

1. COMPANY NAME:_____NAIC#_____
   (NAME LISTED ON THE CERTIFICATION OF AUTHORITY AND/OR ARTICLES ON INCORPORATION)
   D/B/A:_____
   (NAME LISTED ON THE FIELD CERTIFICATE OF ASSUMED NAME)

2. POLICY FORM NUMBER(S):_____

3. COMPANY FILING NUMBER (If Applicable):_____

4. PRODUCT NAME:_____

5. PRODUCT TYPE: FFS PPO POS HMO

6. PPO OR POS PLAN REQUIRES OUT-OF-NETWORK REFERRAL: YES NO

7. MARKET SEGMENT: LG. GROUP SM. GROUP ASSOCIATION INDIVIDUAL

8. THIS FILING IS:

   - A NEW LIMITED HEALTH SERVICE BENEFIT PLAN ( )
   - A REVISION TO A PREVIOUSLY FILED LIMITED HEALTH SERVICE BENEFIT PLAN ( )
   - A STATE GROUP PRODUCT ( )

COMPLETED BY: _____