Kentucky Department Of Insurance
Division of Health Insurance Policy & Managed Care

Supporting Insurer's and Stop-Loss Carrier's Quarterly Report

(Due Within Thirty Days After The End Of Each Calendar Quarter)

Insurer/Carrier:_____ **Federal Tax Id. No.:** _____

D/B/A: _____

P.O. Box: _____ **Street:**_____

City _____ **State:** _____ **Zip:** _____ _____

NAIC No: _____ **NAIC Group No.:** _____

Phone: **(Area Code)** _____ **Fax: (Area Code)** _____

Toll Free No: _____ **E-mail Address:** _____

Contact Person: _____ **PositionTitle:** _____

Note: ***Include information pertaining to health benefit plans. <u>Exclude</u> information pertaining to employees of the Commonwealth of KY, Medicare beneficiaries, Medicaid recipients, and CHAMPUS insureds.***

REPORTING PERIOD: Year: _____ ***(check one)*** ***Qrt:*** **1st _____ 2nd _____ 3rd _____ 4th _____**

TYPE OF INSURER: (*Check Both if Applicable*) Supporting: _____ Stop-Loss Carrier:_____

TOTAL STOP-LOSS HEALTH INSURANCE PREMIUMS EARNED FOR THIS QUARTER: $_____

TOTAL NUMBER OF HEALTH BENEFIT POLICIES IN FORCE BY MARKET TYPE AT THE END OF THIS REPORTING QUARTER: ***(<u>Exclude</u> Stop-Loss Policies)***

Individual _____ **Small Group** _____

Large Group _____ **Association** _____

Employer Organized Association _____

TOTAL HEALTH BENEFIT PREMIUMS EARNED DURING THIS REPORTING QUARTER:

***(<u>Exclude</u> Stop-Loss Premiums)*: $**_____

TOTAL HEALTH BENEFIT PREMIUMS EARNED BY THE FOLLOWING MARKET TYPES DURING THIS REPORTING QUARTER: ***(<u>Exclude</u> Stop-Loss Premiums): (The sum of the following Health Benefit Premiums earned by market type must equal the amount reported above for Total Health Benefit Premiums):***

Individual: $_____ **Small Group: $** _____

Large Group: $_____ **Association: $** _____

Employer Organized Association: $ _____

I, _____, certify the accuracy and validity of the information contained in this report.
Please Print

_____ _____ _____
(Date) ***(Signature)*** ***(Position Title)***