COMMONWEALTH OF KENTUCKY
DEPARTMENT OF INSURANCE
Frankfort, KY 40602-0517

HEALTH BENEFIT PLAN RATE FILING INFORMATION FORM

Company Name _____
(Company name as listed on the certificate of authority and/or the article of incorporation)

NAIC No. _____ FEDERAL TAX ID No. _____

D/B/A _____
(name listed on the filed certificate of assumed name)

Product Marketing Network Name (if any): _____

Contact Person: _____

Mailing Address: _____

Phone Number: _____ Ext. _____ Fax No. _____

E-Mail: _____

Contact Actuary: _____

Mailing Address: _____

Phone Number: _____ Ext. _____ Fax No. _____

E-Mail: _____

To whom should the notification for the **"DATE OF FILING"** be sent:

___ Contact Person ____ Contact Actuary

_____ Other _____ Fax Number

_____ E-mail

Form Number(s) to which this filing applies: _____

DOI Form Filing Number to which this filing applies: _____
(DOI File Number is LOCATED on your return form filing copy)

Company/Insurer Assigned File Number:_____

Requested Effective Date of This Filing: _____

MARKET SEGMENT: Small Group___ Individual___ Large Group____Association_____

OTHER: _____ Employer Organized Association: _____
Employer Organized Association Name

_____ Health Insurance Purchasing Outlet: _____
Health Insurance Purchasing Outlet Name

PRODUCT TYPE: HMO ____ POS ____ PPO ____ FFS _____

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INFORMATION FORM

COMPLETE A SEPARATE PAGE FOR EACH PRODUCT TYPE

Product Type _____

This filing is for: _____ Material change to previously approved DOI Rate Filing #_____
(DOI File No)

_____ New product rates

_____ Change in existing product rates due to:

_____ Projected need for rate change

_____ Geographical region **(Adding or deleting a service area)**

_____ Other change requiring a change in rates

Specify: _____

_____ Rate Change: Increase _____ Decrease _____

DOI File Number for Existing Health Benefit Rates: _____

Effective Date of Existing Health Benefit Rates: _____

ASSESSMENT: Identify the amount of assessments (Kentucky Access/Guaranteed Acceptance Program (GAP)) used in this product's rate development:

Net Assessment (paid minus refund received):

Amount: $ _____

Paid Date: _____

Base New Business Rate:_____

Base New Business Rate Change: _____

Class: _____ Product: _____ _____

Class: _____ Product: _____ _____

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INFORMATION FORM

COMPLETE A SEPARATE PAGE FOR EACH PRODUCT TYPE

Product Type _____

Enter the number of existing Covered Persons in each region

Region	1	2	3	4	5	6	7	8
All Plans								
Standard Plan								
Highest Premium Volume Plan 1								
2nd Highest Premium Volume Plan								
Number								

Total Statewide Covered Persons: _____

I have prepared or supervised the preparation of this Product Information Form for the above policy(ies) and the content is accurate and complete.

_____ _____ _____

Date Signature of Company Representative (Type name of person signing)

_____

(Type title of person signing above)

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HEALTH BENEFIT PLAN RATE FILING
INFORMATION FORM

COMPLETE A SEPARATE PAGE FOR EACH PRODUCT TYPE

Company Name: _____

Market Segment: _____ **Product Type:** _____

Class of Business: Regular _____ **Other:** _____

	Plan Identification	(a) Monthly Premium In Force	(b) Proposed Change in New Business Rate	(c) (a) * (b)
1		$	%	
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				

NOTE: The * indicates "multiplied by."

Total _____ _____

Average increase in base new business rates = Total (c)/Total (a) =
(Attach Additional Pages as Necessary)

Change for each product HMO, FFS, POS, and PPO