Service Area Expansion

1. Name of Company: _____
2. Name of Network submitted: _____
3. Type of Network: _____HMO _____POS _____PPO
4. Indicate every Kentucky county within your approved service area for this network:
   _____
   _____
   _____
5. Indicate every Kentucky county you wish to expand into:
   _____
   _____
   _____
6. Will this network be used on the exchange? _____Yes _____No
7. Under what name (s) do you intend to market this network?
   _____
8. Intended market type(s) (place check mark before each appropriate item):

   _____Individual Market _____Small Group

   _____ Large Groups _____ Individual Associations

   _____ Group Associations _____ Employer Organized Association Group
9. Name and phone number of individual to contact if problems are encountered with submitted files:

   _____ _____ _____
   (Please Print Name) (E-Mail Address) (Phone Number)
10. _____
    (Signature of individual completing this form)

For EACH network expansion you must submit:

(1) One Provider Access database file;

(2) This form completed in its entirety.