Department of Insurance
Division of Health and Life [~~Insurance Policy and Managed Care~~]
Face Sheet and Verification Form [~~(In Duplicate)~~]

_____
DOI ID No

Company	Phone No. (800# if available)	NAIC Company No.	Fed. Tax ID. No.
Address, City, State and Zip Code		Fax Number	E-Mail Address
Form No. *	Description of Filing		Flesch Score

[_____ 1. **CERTIFICATION** ~~Include signed HIPMC-F2 and signed HIPMC-R4, as appropriate. Individual health~~ **POLICY FORMS** ~~policy must include rates, actuarial memorandum, and classifications, if any.~~]

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_____ 1. [~~2.~~] **APPROVAL - FORMS** (Rates must be filed separately) [~~(These filings may not be filed by certification)~~]
( ) Stop Loss ( ) Medicare Supp. ( ) LTC/Nursing Home/Home Health
( ) Short Term Limited Duration [~~HMO~~] ( ) Blanket
( ) LTC Partnership Ins. (LTCPI)
( ) Limited Health Service Benefit Plan (include HIPMC-[~~F-~~37] F-11)
( ) Health Benefit Plan (include HIPMC- F-11) [~~F-35~~] ( ) MEWA
( ) Basic Health Benefit Plan (include HIPMC-RF-25) ( ) Other

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_____ 2.[~~3.~~] **APPROVAL - RATES**
( ) Basic Health Benefit Plan Rates (KRS 304.17A) ( ) Medicare Supplement
( ) Health Benefit Plan Rates (KRS 304.17A) ( ) Long Term Care
( ) Limited Health Service Benefit Plan Rates (KRS 304.17C) ( ) MEWA
( ) Other – [~~Rate Change/Revisions:~~]
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_____ 3. [~~4.~~] **FILED ONLY**
( ) Provider Agreements ( ) Risk Sharing Arrangements
( ) Provider Directory ( ) Advertising

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[_____ 5. **AMENDMENT** ( ) **Previously Approved Health Benefit Plan Rate Filing** ~~DOI FILE NO:_____ Approval Date:_____~~
~~_____~~]

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[_____ 6. **REFERENCE FILING** ~~(For use only when referencing another company's approved filing.)~~
~~Referenced Company Name NAIC #~~
~~Date Approved by KY Department of Insurance Form #~~]

FEES: KRS. 304.4-010 and 806 KAR 4:010 establish filing fees as follow:
a) _____ For [~~for~~] rate level revision filings subject to prior approval;
b) _____ For [~~for~~] other rate and form filings;
c) Your [~~your~~] company's domiciliary state fee of $_____;
[~~and d) a $50.00 filing fee for amendments to previously approved health benefit plan rate filings.~~]
Pursuant to KRS 304.3-270 submit the greater of a), b), or c). [~~or d).~~] Amount submitted $_____.

KRS 304.17A-527 and 806 KAR 17:300 establish filing fees as follows: a) $25.00 for provider agreement; and b) $50.00 for a risk sharing arrangement agreement. Amount submitted: $_____.

A FILING CANNOT BE ACCEPTED UNLESS ACCOMPANIED BY THE APPROPRIATE FEE
(MAKE CHECK PAYABLE TO KENTUCKY STATE TREASURER)

[~~*Applications, benefit riders, certificates of insurance, and disclosure statements will **not** be adopted by reference unless noted above with form numbers.~~]

CERTIFICATION OF PERSON RESPONSIBLE FOR FILING

I certify that I have been authorized by the board of directors or management committee of the company or organization listed above to make this filing.

NAME ([~~Manual~~] Signature Required)	POSITION	DATE

NAME (Print or Type)

[~~*Applications, benefit riders, certificates of insurance, and disclosure statements will **not** be adopted by reference unless noted above with form numbers.~~]