Department of Insurance
Division of Health ~~Insurance Policy and Managed Care~~ and Life

ADDITIONAL HEALTH INFORMATION REQUEST FORM

«Current Date»

«Company_Name»
Attn: «Contact_Person»
«Address1» «Address2»
«City» «State» «Zip»

RE: Co. Ltr Date: «Co_Letter_Date» Fax No: «Fax_No»
Form No: «Form_No»
Co. Filing No.
Date Received: «Date_Received» KY DOI Filing No: «KYDOI_File»

The information referenced above cannot be accepted as submitted because of the following reason(s) and/or omissions:

( ) HIPMC-F1 Face Sheet & Verification form was not submitted. ~~**(Please submit in duplicate)**~~
( ) ~~Incorrect F-1 was submitted~~ Filing fee in accordance with 806 KAR 4:010 or the domiciliary state fee, whichever is greater.
( ) Filing fee of $50.00 for risk sharing agreement pursuant to 806 KAR 17:300, Section 2(3)(b)2.
( ) Filing fee of $25.00 for provider agreement ( ) or subcontract agreement ( ) pursuant to 806 KAR 17:300, Section 2(3) (b)1.
( ) ~~Filing fee of **$5.00** for each single subject of coverage of insurance filed or the domiciliary state fee, whichever is greater.~~ HIPMC-F11 form was not submitted.
( ) ~~Health rate revision - **$100.00** (Reference 806 KAR 4:010)~~
( ) ~~_____ Additional filing fee is required.~~ A Statement of Variability was not submitted.
( ) ~~Certification Form by President (Form HIPMC-F2)~~ Duplicate form numbers were submitted.
( ) ~~Actuarial Certification (Form HIPMC-R4)~~ Revised form letter of explanation was not submitted.
( ) Flesch score (Reference 806 KAR 14:121)
( ) Actuarial Certification (Form HIPMC-R4)
( ) Actuarial ~~Demonstration~~ Memorandum ( ) Rates ( ) Signature on
( ) ~~Flesch score (Reference 806 KAR 14:121)~~
( ) ~~Filing fee of $25.00 for provider agreement ( ) or subcontract agreement ( ) pursuant to 806 KAR 17:300, Section 2(3) (b)1.~~
( ) ~~Filing fee of $50.00 for risk sharing agreement pursuant to 806 KAR 17:300, Section 2(3)(b)2.~~
( ) HIPMC-R36 Rate Filing Information Form
( ) Other

If the requested item(s) are not received within **thirty (30)** days from the date of this letter, the forms involved **will not** be retained for future reference.

~~**For identification purposes, please submit a copy of this letter with the requested item(s) to the Kentucky Department of Insurance, Division of Health Insurance Policy and Managed Care, Attn: _____P.O. Box 517, Frankfort, KY 40602-0517, or 215 West Main Street, Frankfort, KY 40601.**~~

HIPMC-F16 07/2020 [(~~07/2008~~)]