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

**HEALTH BENEFIT PLAN RATE FILING**
**INFORMATION FORM**

Company Name ______________________________________________
**(name 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
______________________ Email

Company/Insurer Assigned File Number:_____________________

**Requested Effective Date of This Filing:** ______________________________

**MARKET SEGMENT:** Small Group______ Individual______ Large Group_______

Association______

**OTHER:** ______ Employer Organized Association(EOA): ____________________________
Employer Organized Association Name

______ Self Insured EOA: ______________________________
Self Insured EOA Name

**PRODUCT TYPE:** HMO ____ POS ____ PPO ____ FFS _____

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# 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: ______________________

Base New Business Rate: ______________________________________

Base New Business Rate Change: ______________________________

Class: ____________________ Product: ______________ ____________

Class: ____________________ Product: ______________ ____________

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# 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 | | | | | | | | |

Total Statewide Covered Persons: ______________________ As of date: ________________________

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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# COMPLETE A SEPARATE PAGE FOR EACH PRODUCT TYPE

**Company Name:** ______________________________

**Market Segment:** ____________ **Product Type:** ____________

**Class of Business: Regular** ______ **Other:** ______________

| | Plan Identification | (a)<br>Monthly Premium<br>In Force | (b)<br>Proposed Change in<br>New Business Rate | (c)<br><br>(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**