Kentucky Department of Insurance
Division of Health and Life Insurance [~~Policy and Managed Care~~]
Health Care Financing Branch
***RATE FILING INFORMATION FORM (Limited Benefits)**
*** (This form is not required with Health Benefit Plan Rate Filings in KRS 304.17A)**

Company	**NAIC Company No.**
Contact Person	**E-Mail Address**
Phone No. (800 # if available) / **EXT.**	**Fax Number**
Form No(s).	**No of Forms**

****

CHECK ALL APPLICABLE: * This does not apply to Health Benefit Rate Filings

TYPE OF POLICY:

[~~( ) Accident~~] [~~( ) Hospital Indemnity~~] [~~( ) Medicare Supplement Standardized~~]
[~~( ) Cancer~~] [~~( ) Hospital/Medical/Surgical~~] [~~( ) Short Term Nursing Home~~]
[~~( ) Dental~~] [~~( ) Long Term Care~~] [~~( ) Student~~]
[~~( ) Disability~~] [~~( ) LTCPI (LTC Partnership Insurance)~~] [~~( ) Vision~~]
[~~( ) Home Health~~] [~~( ) Medicare Supplement Pre-Standardized~~] [~~( ) Other _____~~]

☐ Accident	☐ Long Term Care	☐ Medicare Supplement Pre-Standardized
☐ Cancer	☐ LTCPI (LTC Partnership Insurance)	☐ Medicare Supplement Standardized
☐ Specified Disease	☐ Short Term Nursing Home	☐ Medicare Supplement Modernized
☐ Hospital Indemnity	☐ Home Health	☐ Disability
☐ Hospital/Medical/Surgical	☐ Dental	☐ Short Term Limited Duration
☐ Student	☐ Vision	☐ Other _____

REQUIRED ANNUAL MEDICARE SUPPLEMENT FILING: ☐ [~~( )~~]

MARKET TYPE: ☐ [~~( )~~] Individual ☐ [~~( )~~]Group ☐ [~~( )~~]KY Retirement/Group Seniors

AVAILABILITY: **PREMIUM STRUCTURE:**

☐ [~~( )~~]Closed Block ☐ [~~( )~~]Open Block ☐ [~~( )~~]Attained Age ☐ [~~( )~~] Issue Age
☐ [~~( )~~]Community

☐ [~~( )~~]Other_____

RENEWAL CATEGORIES:

☐ [~~( )~~]OR-Optionally renewable ☐ [~~( )~~]CR- Conditionally renewable
☐ [~~( )~~]GR- Guaranteed renewable ☐ [~~( )~~]NC- Noncancelable

FILING INFORMATION:

Range in Rate Structure (area, age slope, etc.) Yes_____ No _____ **Previous Rate Filing DOI #_____**

Rate % Increase Requested: _____ **Range of Rate Increase: _____**

Estimated Average Annual Premium *before* Increase: _____

Estimated Average Annual Premium *after* Increase: _____

No. of Kentucky Policies: _____ **No. of National Policies: _____**

Requested Filing Effective Date: _____ **Original Filing Date: _____**

Previous Increase Effective Date: _____ **Amount of Last Approved Increase: _____**
