Cabinet for Health and Family Services [Department of Insurance] Office of Health Data and Analytics [Division of Health Insurance Policy and Managed Care]

Affidavit

	MONWEALTH OF KENTUCKY)) Sct.
	NTY OF)	, having first being duly sworn, depose and say as
	(Please Print)	follows:
A.	whose NAIC# is	(Company) ,
	and am duly authorized to make this	s Affidavit on its behalf.
B.	I declare that the information conta all purposes is true and correct.	ined in the attached letter and incorporated herein fo
C.		ne, I become aware that information contained in the mmediately disclose the discrepancy in writing to the
Name:		Phone:
	(Signature) Chief Executive Officer	
Addres	ss (if different from above):	
Sworn	to before me and subscribed in my p	presence this, day of,
[Notar	rial Seal]	Notary Public,County, Kentucky
		My commission expires: