

LICENSEE CONTACT INFORMATION FOR ACCIDENT AND HEALTH INSURERS

Complete the following information for each licensed company or line of business. If providing information for more than one licensed company or line of business, submit separate sheets for each.

1. Insurer / HMO Name _____

2. Address _____

(city)

(state)

(zip)

3. Identify Licensure Type (Please Check Only One. If More than One Applies, Please Complete Additional Sheets for Each Licensee):

- | | |
|--|--|
| <input type="checkbox"/> Accident and Health Insurance Company | <input type="checkbox"/> Article 43 Corporation |
| <input type="checkbox"/> Continuing Care Retirement Communities | <input type="checkbox"/> Fraternal Benefit Society |
| <input type="checkbox"/> HMO | <input type="checkbox"/> Life Insurance Company |
| <input type="checkbox"/> Municipal Cooperative Health Benefit Plan | <input type="checkbox"/> Property Casualty Company |

4. Identify the accident and health insurance coverage you are currently offering under the licensure type identified in (3) above and identify the markets in which the coverage is offered (Check all that apply):

Key for Markets: Individual (IND) Small group (2- 50 lives) (SG) Large group (51 and above) (LG) Blanket (B)

Coverage

Markets

- | | | | | |
|---|------------------------------|-----------------------------|-----------------------------|----------------------------|
| <input type="checkbox"/> Accident Only | <input type="checkbox"/> IND | <input type="checkbox"/> SG | <input type="checkbox"/> LG | <input type="checkbox"/> B |
| <input type="checkbox"/> Accidental Death and Dismemberment | <input type="checkbox"/> IND | <input type="checkbox"/> SG | <input type="checkbox"/> LG | <input type="checkbox"/> B |
| <input type="checkbox"/> Continuing Care Retirement Community | <input type="checkbox"/> IND | <input type="checkbox"/> SG | <input type="checkbox"/> LG | |
| <input type="checkbox"/> Dental Only | <input type="checkbox"/> IND | <input type="checkbox"/> SG | <input type="checkbox"/> LG | <input type="checkbox"/> B |
| <input type="checkbox"/> Disability Income | <input type="checkbox"/> IND | <input type="checkbox"/> SG | <input type="checkbox"/> LG | <input type="checkbox"/> B |
| <input type="checkbox"/> HMO | <input type="checkbox"/> IND | <input type="checkbox"/> SG | <input type="checkbox"/> LG | |
| <input type="checkbox"/> Hospital Indemnity | <input type="checkbox"/> IND | <input type="checkbox"/> SG | <input type="checkbox"/> LG | <input type="checkbox"/> B |
| <input type="checkbox"/> Hospital, Surgical, and/or Medical Expense | <input type="checkbox"/> IND | <input type="checkbox"/> SG | <input type="checkbox"/> LG | <input type="checkbox"/> B |
| <input type="checkbox"/> Long Term Care | <input type="checkbox"/> IND | <input type="checkbox"/> SG | <input type="checkbox"/> LG | |
| <input type="checkbox"/> Long Term Care Partnership | <input type="checkbox"/> IND | <input type="checkbox"/> SG | <input type="checkbox"/> LG | |
| <input type="checkbox"/> Medicare Supplement/Select | <input type="checkbox"/> IND | <input type="checkbox"/> SG | <input type="checkbox"/> LG | |
| <input type="checkbox"/> Nursing Home and/or Home Care | <input type="checkbox"/> IND | <input type="checkbox"/> SG | <input type="checkbox"/> LG | |
| <input type="checkbox"/> Prescription Drug | <input type="checkbox"/> IND | <input type="checkbox"/> SG | <input type="checkbox"/> LG | <input type="checkbox"/> B |
| <input type="checkbox"/> Provider Excess Loss | <input type="checkbox"/> IND | <input type="checkbox"/> SG | <input type="checkbox"/> LG | |
| <input type="checkbox"/> Specified Disease | <input type="checkbox"/> IND | <input type="checkbox"/> SG | <input type="checkbox"/> LG | <input type="checkbox"/> B |
| <input type="checkbox"/> Statutory Conversion (Ins. Law §3221(e)) | <input type="checkbox"/> IND | <input type="checkbox"/> SG | <input type="checkbox"/> LG | |
| <input type="checkbox"/> Statutory Disability Benefits Law (DBL) | <input type="checkbox"/> IND | <input type="checkbox"/> SG | <input type="checkbox"/> LG | |
| <input type="checkbox"/> Stop Loss | | | <input type="checkbox"/> LG | |
| <input type="checkbox"/> Travel Insurance | <input type="checkbox"/> IND | <input type="checkbox"/> SG | <input type="checkbox"/> LG | <input type="checkbox"/> B |
| <input type="checkbox"/> Vision Only | <input type="checkbox"/> IND | <input type="checkbox"/> SG | <input type="checkbox"/> LG | <input type="checkbox"/> B |

5. Authority to Write:

- Authorized to write and currently writing accident and health insurance.
- Authorized to write accident and health insurance, but not currently writing, and have existing closed blocks of such coverage.
- Authorized to write accident and health insurance, but not currently writing, and do not have any closed blocks of such coverage.

6. Identify the government programs you participate in under the licensure type identified in (3) above (Check all that apply):

- Child Health Plus Medicaid Managed Care
 Family Health Plus Medicare Advantage
 Healthy New York Medicare Part D

7. If your company is a Commercial Insurer, an Article 43 Corporation, or a Municipal Cooperative Health Benefit Plan that includes health insurance coverage through a network of participating providers, identify the following for each preferred provider organization (PPO) and exclusive provider organization (EPO) Product:

| The policy form number of the PPO product | The marketing name of the PPO product | The number of insureds covered under the PPO product (as of 12/31/07) |
|---|---------------------------------------|---|
| | | |
| | | |
| | | |
| | | |

| The policy form number of the EPO product | The marketing name of the EPO product | The number of insureds covered under the EPO product (as of 12/31/07) |
|---|---------------------------------------|---|
| | | |
| | | |
| | | |
| | | |

8. If your company is currently writing accident and health insurance coverage, provide the following contact information for: (A) the government relations contact person you would like us to contact with complaints and inquiries, (B) the regulatory compliance contact person you would like us to contact regarding policy form issues, (C) your company's chief executive officer, (D) your company's annual statement contact person, (E) your company's chief actuary, (F) the person you would like us to contact with respect to the Regulation 146 Specified Medical Condition Pools, (G) the person you would like us to contact with respect to the Healthy New York Program and (H) the person you would like us to contact for preferred provider organization quality assurance information.

A. Name of Contact Person for Complaints / Inquiries _____

Address if different from item (2) above _____

Telephone Number _____ Fax Number _____

E-mail Address _____

B. Name of Contact Person for Policy Forms _____

Address if different from item (2) above _____

Telephone Number _____ Fax Number _____

E-Mail Address _____

C. Name of Chief Executive Officer _____

Address if different from item (2) above _____

Telephone Number _____ Fax Number _____

E-Mail Address _____

D. Name of Annual Statement Contact Person _____

Address if different from item (2) above _____

Telephone Number _____ Fax Number _____

E-Mail Address _____

E. Name of Chief Actuary _____

Address if different from item (2) above _____

Telephone Number _____ Fax Number _____

E-Mail Address _____

F. Name of Regulation 146 Contact Person _____

Address if different from item (2) above _____

Telephone Number _____ Fax Number _____

E-Mail Address _____

G. Name of Healthy New York Contact Person _____

Address if different from item (2) above _____

Telephone Number _____ Fax Number _____

E-Mail Address _____

H. Name of Contact Person for PPO / EPO Quality Assurance Information _____

Address if different from item (2) above _____

Telephone Number _____ Fax Number _____

E-Mail Address _____