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:**

[ ] Accident and Health Insurance Company
[ ] Continuing Care Retirement Communities
[ ] HMO
[ ] Municipal Cooperative Health Plan
[ ] Article 43 Corporation
[ ] Fraternal Benefit Society
[ ] Life Insurance Company
[ ] Property Casualty Company

4. **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.

5. **Identify coverage you are currently offering and identify the markets in which these products are offered (Check all that apply):**

*Key: Individual direct payment **(IDP)** Small group (2- 50 lives) **(SG)** Large group (50 and above) **(LG)***

[ ] Accident Only	[ ] IDP	[ ] SG	[ ] LG
[ ] Child Health Plus	[ ] IDP	[ ] SG	[ ] LG
[ ] Continuing Care Retirement Community	[ ] IDP	[ ] SG	[ ] LG
[ ] Dental Only	[ ] IDP	[ ] SG	[ ] LG
[ ] Disability Income	[ ] IDP	[ ] SG	[ ] LG
[ ] Healthy New York	[ ] IDP	[ ] SG	[ ] LG
[ ] HMO	[ ] IDP	[ ] SG	[ ] LG
[ ] Hospital Indemnity	[ ] IDP	[ ] SG	[ ] LG
[ ] Hospital, Surgical, and/or Medical Expense	[ ] IDP	[ ] SG	[ ] LG
[ ] Long Term Care	[ ] IDP	[ ] SG	[ ] LG
[ ] Long Term Care Partnership	[ ] IDP	[ ] SG	[ ] LG
[ ] Medicaid Managed Care	[ ] IDP	[ ] SG	[ ] LG
[ ] Medicare Managed Care	[ ] IDP	[ ] SG	[ ] LG
[ ] Medicare Supplement/Select	[ ] IDP	[ ] SG	[ ] LG
[ ] Nursing Home and/or Home Care	[ ] IDP	[ ] SG	[ ] LG
[ ] Prescription Drug	[ ] IDP	[ ] SG	[ ] LG
[ ] Provider Excess Loss	[ ] IDP	[ ] SG	[ ] LG
[ ] Specified Disease	[ ] IDP	[ ] SG	[ ] LG
[ ] Statutory Conversion (Ins. Law §3221(e))	[ ] IDP	[ ] SG	[ ] LG
[ ] Statutory Disability Benefits Law (DBL)	[ ] IDP	[ ] SG	[ ] LG
[ ] Stop Loss	[ ] IDP	[ ] SG	[ ] LG
[ ] Travel Insurance	[ ] IDP	[ ] SG	[ ] LG
[ ] Vision Only	[ ] IDP	[ ] SG	[ ] LG

Continued on next page.

6. **If your company is currently writing accident and health insurance or HMO coverage, provide the following information for:** 1) the government relations contact person you would like us to contact with complaints and inquiries, 2) the regulatory compliance contact person you would like us to contact regarding policy form issues, 3) your company's chief executive officer, 4) your company's annual statement contact person, 5) your company's chief actuary and 6) the person you would like us to contact with respect to the Regulation 146 Specified Medical Condition Pools.

1. **Name of Government Relations Contact Person** ______________________________

Address if different from above ______________________________

Telephone Number______________________ Fax Number ______________________

E-mail Address ______________________________

2. **Name of Regulatory Compliance Contact Person (if different)** ______________________

Address if different from above ______________________________

Telephone Number______________________ Fax Number ______________________

E-Mail Address ______________________________

3. **Name of Chief Executive Officer** ______________________________

Address if different from above ______________________________

Telephone Number______________________ Fax Number ______________________

E-Mail Address ______________________________

4. **Name of Annual Statement Contact Person** ______________________________

Address if different from above ______________________________

Telephone Number______________________ Fax Number ______________________

E-Mail Address ______________________________

5. **Name of Chief Actuary** ______________________________

Address if different from above ______________________________

Telephone Number______________________ Fax Number ______________________

E-Mail Address ______________________________

6. **Name of Regulation 146 Contact Person** ______________________________

Address if different from above ______________________________

Telephone Number______________________ Fax Number ______________________

E-Mail Address ______________________________