Department of Insurance
Division of Health Insurance Policy and Managed Care
Face Sheet and Verification Form (In Duplicate)

_____	_____	_____	_____
Company No.	Phone No. (800# if available)	NAIC Company No.	Fed. Tax ID.
_____		_____	_____
Address, City, State and Zip Code		Fax Number	E-Mail Address
_____	_____		_____
Form No. *	Description of Filing		Flesch Score

_____ 1. **CERTIFICATION POLICY FORMS** Include signed HIPMC-F2 and signed HIPMC-R4, as appropriate. Individual health policy must include rates, actuarial memorandum, and classifications, if any.

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_____ 2. **APPROVAL - FORMS** (These filings may not be filed by certification)

( ) Stop Loss ( ) Medicare Supp. ( ) LTC/Nursing Home/Home Health
( ) HMO ( ) Blanket ( ) LTC Partnership Ins. (LTCPI)
( ) Limited Health Service Benefit Plan (include HIPMC-F-37)
( ) Health Benefit Plan (include HIPMC-F-35)
( ) Basic Health Benefit Plan (include HIPMC-RF-25)

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_____ 3. **APPROVAL - RATES**

( ) Basic Health Benefit Plan Rates (KRS 304.17A)
( ) Health Benefit Plan Rates (KRS 304.17A)
( ) Limited Health Service Benefit Plan Rates (KRS 304.17C)
( ) Other – Rate Change/Revisions: _____

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_____ 4. **FILED ONLY**

( ) Provider Agreements ( ) Risk Sharing Arrangements
( ) Provider Directory ( ) Advertising

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_____ 5. **AMENDMENT**

( ) **Previously Approved Health Benefit Plan Rate Filing**
DOI FILE NO:_____ Approval Date:_____

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_____ 6. **REFERENCE FILING** (For use only when referencing another company's approved filing.)

_____	_____
Referenced Company Name	NAIC #
_____	_____
Date Approved by KY Department of Insurance	Form #

FEES: KRS. 304.4-010 and 806 KAR 4:010 establish filing fees as follow: a) _____ for rate level revision filings subject to prior approval; b) _____ for other rate and form filings; c) your company's domiciliary state fee of $_____; and d) a $50.00 filing fee for amendments to previously approved health benefit plan rate filings. Pursuant to KRS 304.3-270 submit the greater of a), b), c), or d). Amount submitted $_____.

KRS 304.17A-527 and 806 KAR 17:300 establish filing fees as follows: a) $25.00 for provider agreement; and b) $50.00 for a risk sharing arrangement agreement. Amount submitted: $_____.

A FILING CANNOT BE ACCEPTED UNLESS ACCOMPANIED BY THE APPROPRIATE FEE (MAKE CHECK PAYABLE TO KENTUCKY STATE TREASURER)

CERTIFICATION OF PERSON RESPONSIBLE FOR FILING

I certify that I have been authorized by the board of directors or management committee of the company or organization listed above to make this filing.

_____	_____	_____
NAME (Manual Signature Required)	POSITION	DATE

_____
NAME (Print or Type)

*Applications, benefit riders, certificates of insurance, and disclosure statements will **not** be adopted by reference unless noted above with form numbers.